Highlights

of the Prince Edward Island Report on

Common Health Indicators

September 2002

Health
Outcomes

Service
Quality

Health Indicators

This document provides highlights of the ***Prince Edward Island Report on Common Health Indicators*** released in September 2002, further to the 2000 First Ministers Agreement on Health. The full report is available by contacting the Department of Health and Social Services, or by visiting our web site at www.gov.pe.ca/hss

The report contains data on how Prince Edward Island compares to the Canadian average. Indicators offer a meaningful snapshot of what is happening right now. While they do not provide the full picture, over time indicators provide trends which may be used to measure, track and report to the public on health status and health system performance. The most current year of data available is reported.

In general, P.E.I. fares well in the report. There are areas where there is room for improvement, and other areas where our results are better than the Canadian average.

Compared to the national average, P.E.I. had:

HEALTH STATUS
- similar life expectancy
- similar infant mortality rates
- similar rates of low birth weight
- similar percentage of people reporting their health is very good or excellent

HEALTH OUTCOMES
- similar death rates due to lung, colorectal, prostate cancer and stroke
- higher death rate due to breast cancer
- lower death rate due to heart attack
- similar prevalence of diabetes
- lower rates of vaccine-preventable diseases

QUALITY OF SERVICE
- similar level of patient satisfaction with services
- shorter wait times for non-emergency surgery
- similar percentage with a family doctor
- more difficulty accessing immediate care during evenings and weekends
- higher rates of hospitalization for conditions that could be treated in the community
- lower rates of new cases of tuberculosis and HIV diagnoses
- similar rates of teens reporting smoking
- similar percentage of people reporting being physically active
- higher rates of being overweight
- similar rates of immunization for the flu

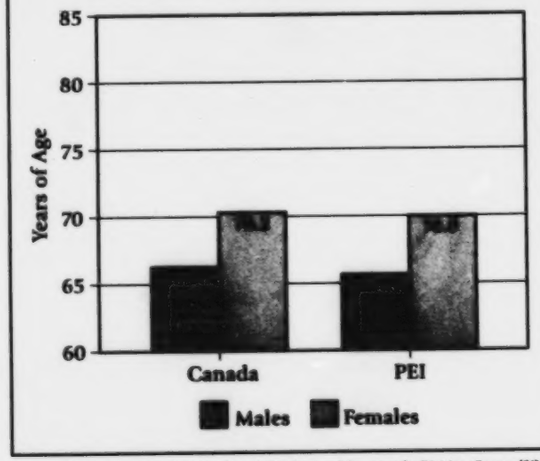
Health Status

Health status indicators are commonly used measures of the overall health of a population. Islanders continue to do well in life expectancy, disability-free life expectancy, infant mortality and self-rated health.

Life expectancy indicates the number of years a person would be expected to live, on average, starting from birth.

- In 1999, PEI had a life expectancy rate of 78.4 years, similar to the national rate of 79.0 years. Island women were expected to live 5.5 years longer than men.

Disability-free life expectancy at birth, 1996



Source: Statistics Canada, Vital Statistics, Death Database and Demography Division; Census; ISQ

Disability-free life expectancy shows us the number of years a person is expected to live, on average, free of moderate or severe disability (experiencing at least one activity limitation).

- In 1996, even though Islanders had a life expectancy of 77.2 years, 67.6 of those years were dis... and the other 9.6 of those years w... d with a moderate or seve... ...y. This rate was si...

- In 1996, Island women were expected to have 4.7 more disability free years than men.

Infant mortality is a measure of child health and refers to the number of infants who die in the first year of life.

- In 1999, PEI had a low infant mortality rate of 6.6 per 1,000, which was close to the national average of 5.3 and lower than the average rate of 7.3 for most developed countries. This rate has been falling since 1980.

Low birth weight refers to the number of live babies born with a birth weight between 500 and 2500 grams which can affect their survival, health and development.

- In 1999, PEI had a low rate of low birth weight babies of 5.2%, similar to the national averageof 5.5%. This rate remained virtually the same for PEI and Canada for the two decades since 1980.

Self-reported health is a reflection of how healthy individuals feel they are.

- A large percentage of Islanders (64.4%) surveyed in the Canadian Community Health Survey in 2000/01 reported their health as "very good" or "excellent", higher than the Canadian average of 61.4%.
- More Islanders in the older age groups reported very good to excellent health than in the younger groups

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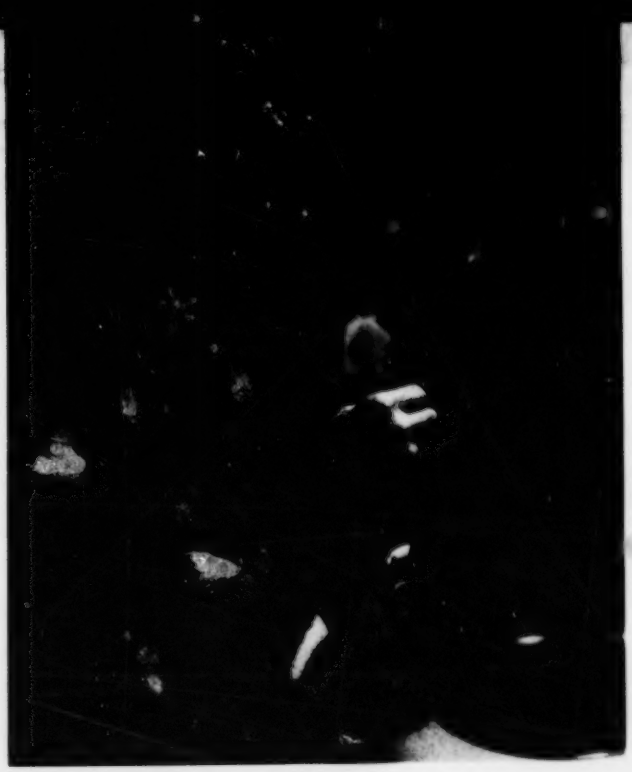
Health Outcomes

Indicators in this category describe how health system programs and services affect the health status of the people who use them. The picture here for PEI is mixed.

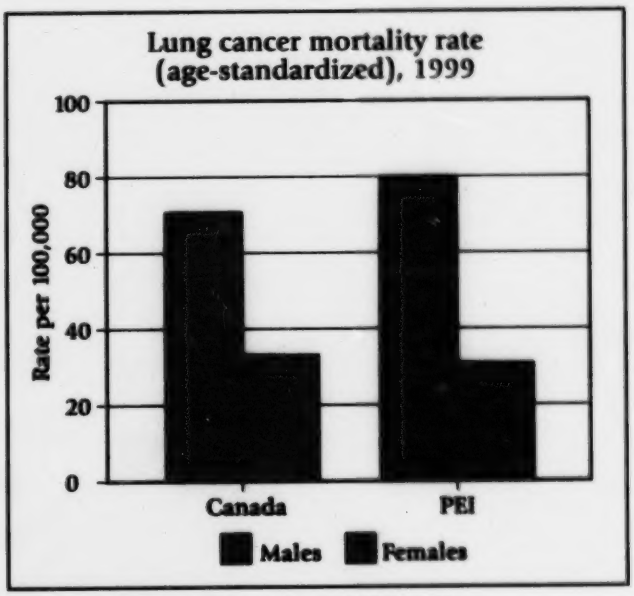
Mortality rates tell us how many people die per year due to particular diseases such as lung, colorectal, prostate or breast cancer, heart attack or stroke.

- Of these six conditions, lung cancer and heart attack were the leading causes of death in PEI.
- The high rate of lung cancer deaths in PEI may reflect our high incidence (new cases) of that cancer.
- PEI cancer death rates were similar to the Canadian average except for breast cancer where PEI was higher.
- The lung cancer death rate increased somewhat from 1980 to 1999 whereas the colorectal, breast and prostate cancer death rates changed little.



Mortality Rates (age-standardized), 1999 - Rate is per 100,000 population

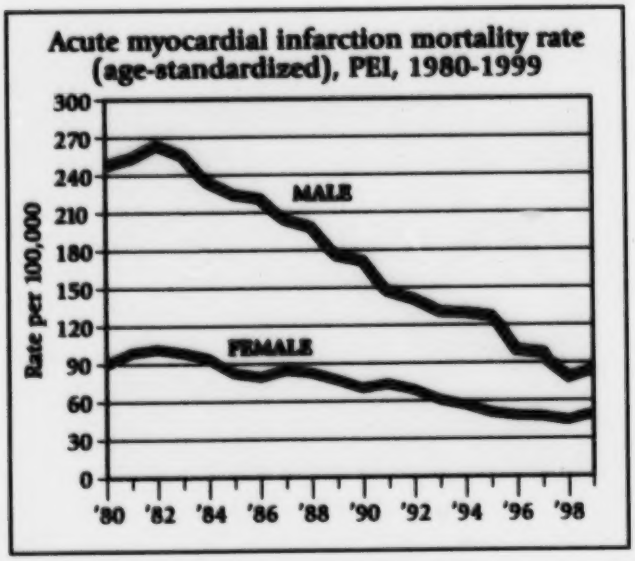
Canada	**50**	**19.1**	**25.2**	**26.7**	**60.2**	**37.0**
PEI	**53.6**	**19.0**	**34.4**	**26.4**	**49.1**	**37.7**



Source: Statistics Canada, Vital Statistics, and Demography Division, ISQ

- The male lung cancer death rate for PEI and Canada was somewhat higher than for females.
- The PEI heart attack (acute myocaridal infarction) death rate was lower than the national average and declined continuously from 1980 to 1999.
- The male heart attack death rates for PEI, like those for Canada, were higher than those for females.

Note: Heart attack (or acute myocardial infarction) should not be confused with heart disease in general which includes all heart conditions, or with cardio-vascular disease which includes stroke.



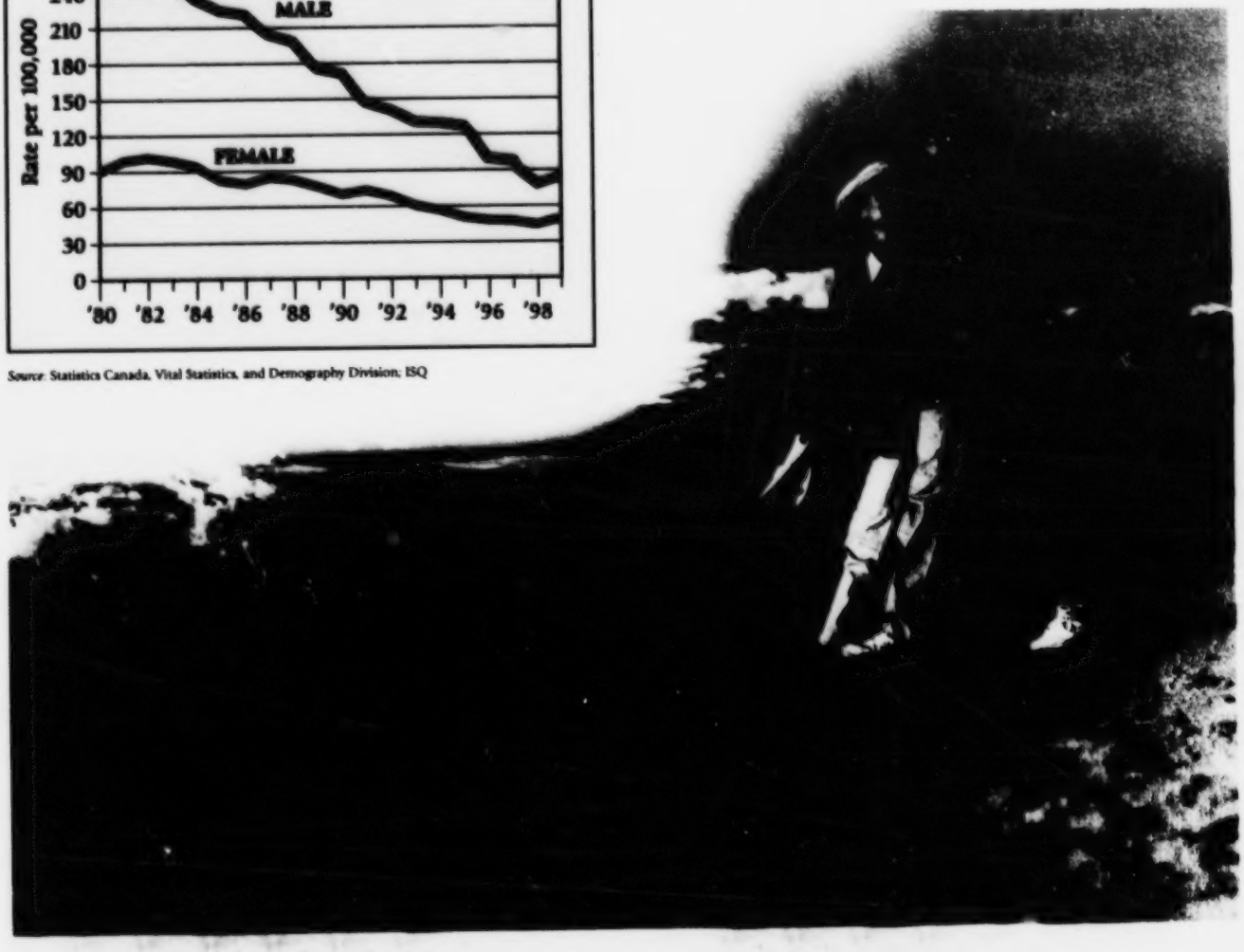
Source: Statistics Canada, Vital Statistics, and Demography Division; ISQ

- PEI stroke death rates were similar to the national average and remained steady over the years.
- Male stroke death rates for PEI and Canada were somewhat higher than for females.

Improved quality of life

One of the key outcomes of the health care system is an improved quality of life for people who use the system. Research has shown that health-related quality of life improves for most people receiving hip and knee replacement surgery.

- The PEI rate of hip replacement of 63.5 per 100,000, was similar to the Canadian average of 59.5 in 1999/00.
- The PEI knee replacement rate of 67.1 per 100,000 was also close to the Canadian average of 65.6.



- In contrast to the Canadian picture, the PEI rate for males for both procedures was somewhat higher than that for females.

Incidence rates of vaccine-preventable diseases (new cases in a given year) can give a sense of the effectiveness of immunization programs.

- PEI had very low incidence rates with only two cases of invasive meningococcal disease (meningitis) since 1993, no cases of measles and only one case of invasive haemophilus influenzae b (Hib) disease.

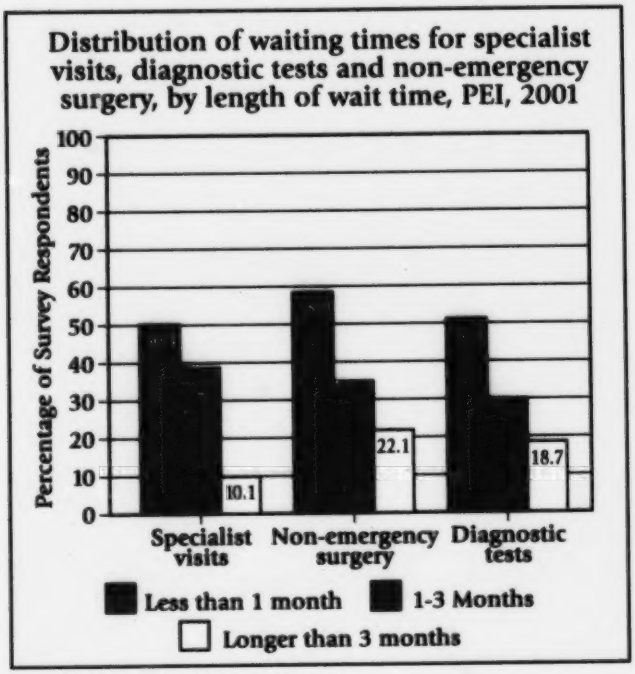
Prevalence of diabetes gives us an idea of the importance or burden of this serious disease at a given point in time.

- Provisional data for both PEI and Canada shows that the prevalence of diabetes in both PEI and Canada was similar from 1997/1998 to 1999/00 at an average of 4.3% population for PEI and 4.7% for Canada.
- The rate over three years shows a steady increase in the prevalenc of diabetes for PEI and Canada.
- Across the age groups for PEI, the rate steadily increases and the rate for males in each age group is consistently higher than the rat for females. For example, the rate for males age 40 to 49 is 3.1% whereas the rate for males age 65 to 69 is 14.3%.

Quality of Service

Quality of service is often assessed by public perception of issues such as wait times, satisfaction with service and access to services.

Islanders generally spoke positively about the quality of care they received.



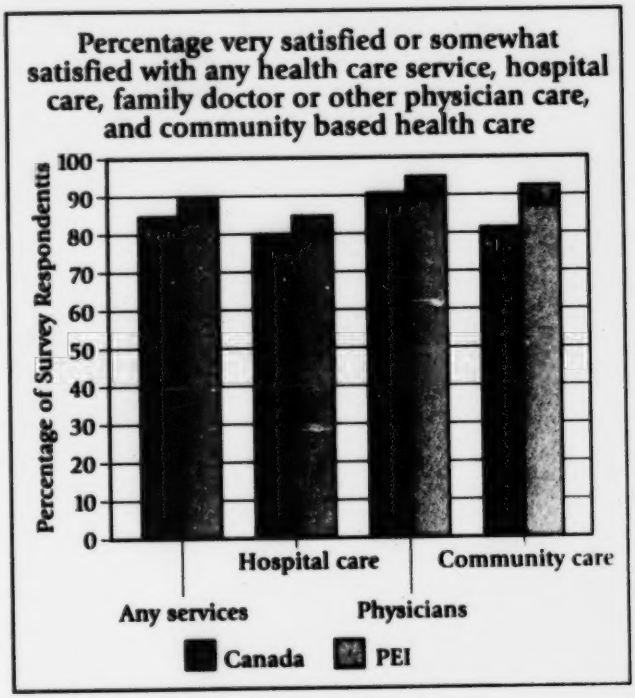
Source: Health Services Access Survey– Nov-Dec 2001

Reported wait times refers to the length of time between when a patient is referred for specialist physician services, non-emergency surgery or diagnostic testing and when they actually received the service.

- For all three types of service in 2000/01, 50% to 60% of Island respondents waited less than one month, between 30% and 40% waited from one to three months and between 10% and 22% waited for more than three months. These rates were similar to the national average.

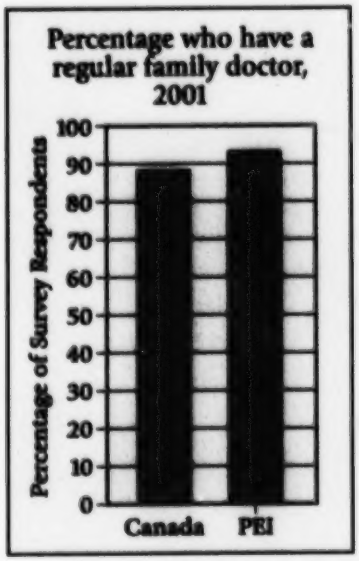
Patient satisfaction was measured as the percentage of the adult population who rated themselves as either "very" satisfied or "somewhat" satisfied with the way a variety of health care services were provided.

- In 2001, Islanders, like Canadians as a whole, were satisfied with the health care services they received.



Source: Canadian Community Health Survey - Cycle 1.1 2000/01

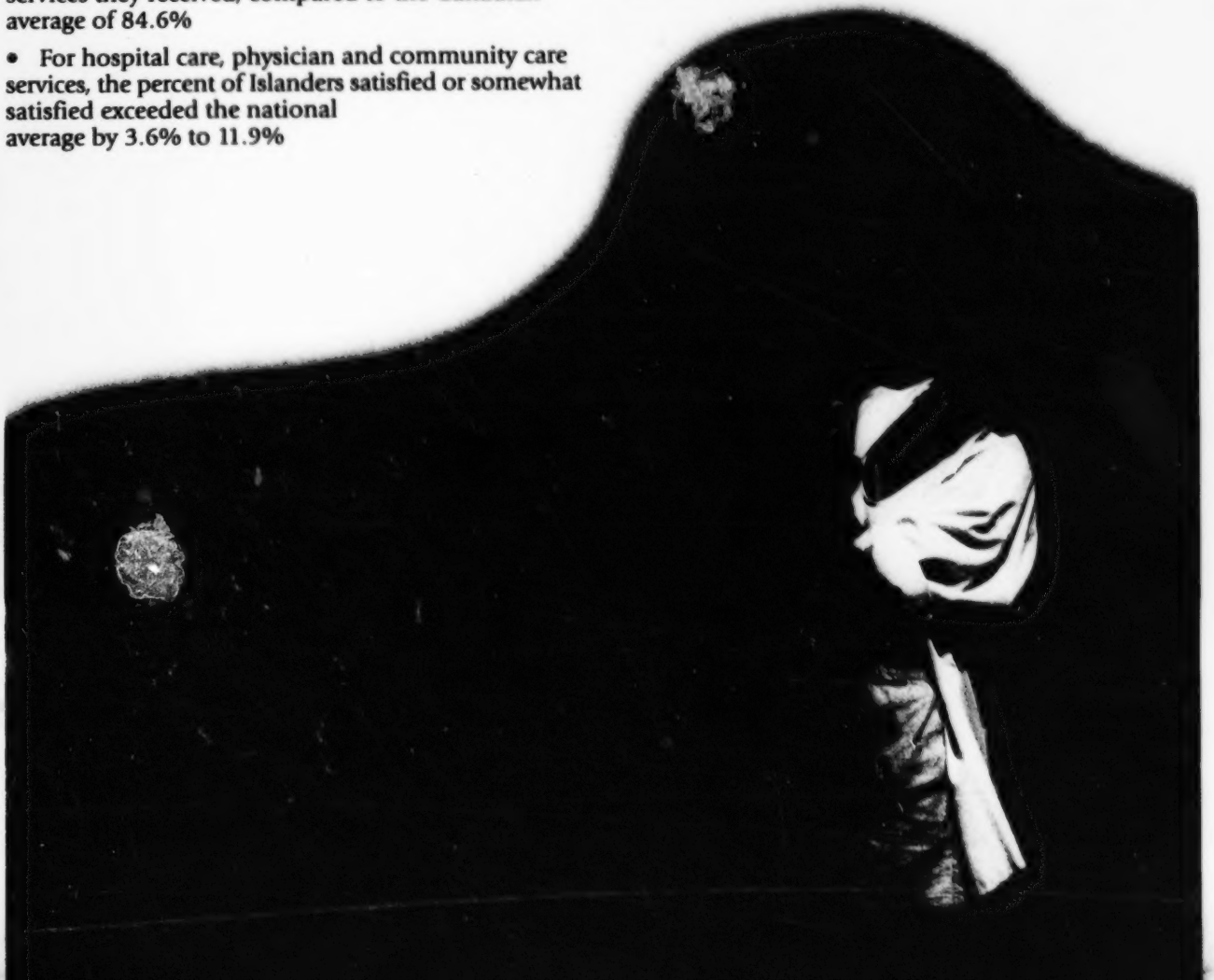
- 89.5% of Islanders reported that they were satisfied or somewhat satisfied with any health care services they received, compared to the Canadian average of 84.6%
- For hospital care, physician and community care services, the percent of Islanders satisfied or somewhat satisfied exceeded the national average by 3.6% to 11.9%

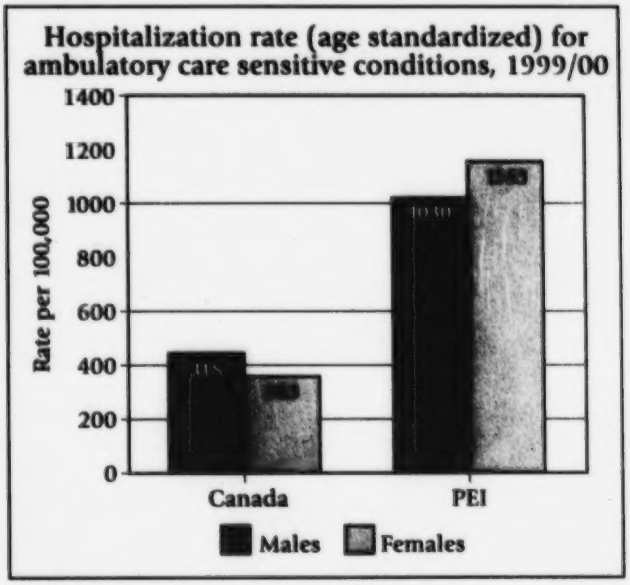


Source : Health Services Access Survey- Nov.-Dec. 2001

Access to a regular family doctor and establishing an on-going relationship with a family doctor is believed to be important in maintaining health and ensuring appropriate access to health services.

- In 2000/01, a very high percentage of PEI respondents (93.6%) and Canadians as a whole (87.7%) reported that they had a family doctor.





Source: Hospital Morbidity Database, CIHI. Census, Statistics Canada, ISQ

Hospitalization rates for ambulatory care sensitive conditions, that is, those conditions which can be cared for in the community are one indicator of appropriate use of hospital beds and access to community-based care.

- In 1999/00, PEI had a much higher hospitalization rate for ambulatory care sensitive conditions at 1,095 per 100,000 than the national rate of 401.
- This rate was consistently higher for PEI since 1995/96.

Public Health Surveillance and Protection

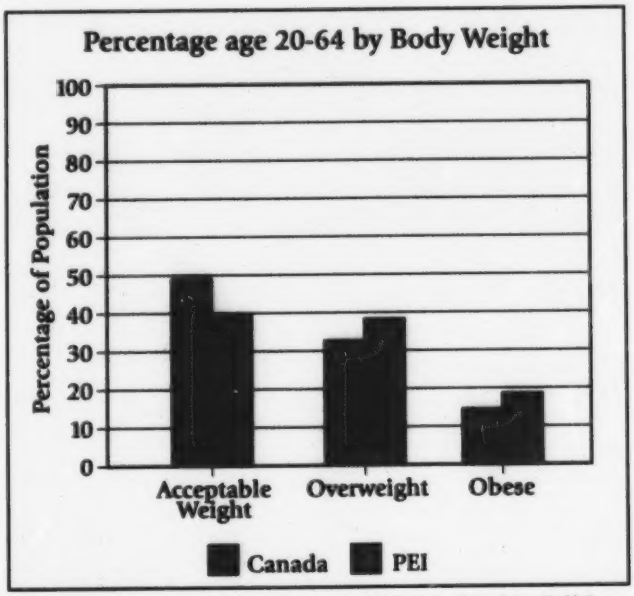
Communicable / notifiable diseases and their spread are a public health concern. The incidence rates of these diseases give us an indication of the effectiveness of prevention programs such as immunization.

- In 1999, PEI had a very low rate of **infectious pulmonary tuberculosis** of 1.5 per100,000 compared to the national average of 5.9.
- In 2001, PEI/Nova Scotia had a low rate of **reported HIV diagnoses** of 0.9 per 100,000 compared to than the national rate of 7.1. Note: Only data that combines PEI and Nova Scotia is available
- In 2001, PEI had an rate of **verotoxogenic *E. coli*** of 12.3 per 100,000 population which was considerably higher than the national average of 4.0. **Note: This may be because it is a reportable disease in PEI, but not in all other provinces or territories.**
- In 2000, the PEI rate of **chlamydia** was 166.3 per 100,000 population just above the national average of 151.1. The incidence rate for females between 15 and 19 was particularly high.

Health Promotion and Disease Prevention

Life habits and choices that pose health risks continue to be a major issue for Islanders. These indicators were measured through items on the Canadian Community Health Survey in 2000/01.

- **Teenaged smokers** - About 15% of Island teenagers were self-reported current smokers, compared to the national average of 18.7%. For PEI and Canada, approximately three quarters reported that they smoked on a daily basis.
- **Physical activity** - Only 19.6% of Islanders and 21% of Canadians reported being physically active. Being physically active in PEI declined with age, with a large decrease from the 12-19 age group to the 20-34 age group.
- **Body weight** - This is calculated by body mass index (BMI) from self-reported height and weight.
- In 2000/01, 39.6% of Islanders were of acceptable weight (BMI=18.5-24.9) compared to 48.3% for the national average.
- 38.1% of Islanders were overweight (BMI=25-29.9) compared to 32.5% for the national average.
- 18.7% of Islanders were obese (BMI=30+) compared to 14.9% for the national average.



Source: Canadian Community Health Survey - Cycle 1.1, 2000/01; National Population Health Survey, 1994, 1996, 1998

Prince Edward Island Report on Common Health Indicators

contains information on:

HEALTH STATUS

- Life expectancy
- Disability-free life expectancy
- Infant mortality
- Low birth weight
- Self-reported health

HEALTH OUTCOMES

- Mortality rates for cancers, acute myocardial infarction and stroke
- 30-day in-hospital mortality rates for heart attack and stroke
- Total hip replacement and knee replacement rates
- Incidence rates for lung, colorectal, prostate and breast cancer
- Potential years of life lost due to cancers, heart attack, stroke, unintentional injury and suicide
- Incidence rates of vaccine-preventable diseases
- Prevalence of diabetes

QUALITY OF SERVICE

- Wait times for specialist visits, diagnostic tests, and non-emergency surgery
- Patient satisfaction with any health care service, hospital care, physician care, and community based care
- Hospital re-admission rates for heart attacks and pneumonia
- Difficulties obtaining routine or on going health services, health information or advice and immediate care
- Percentage having a regular family doctor
- Admissions to home care services
- Percentage of population receiving homemaking, nursing or respite services
- Hospitalization rate for ambulatory care sensitive conditions
- Incidence rates tuberculosis, reported HIV diagnosis, verotoxogenic E. coli, and chlamydia
- Exposure to environmental tobacco smoke
- Teenage smoking rates
- Physical activity rates
- Body weight
- Immunization for influenza rates

Faits saillants
provenant du rapport sur les indicateurs de santé communs de l'Île-du-Prince-Édouard

Septembre 2002

Indicateurs de santé

Le présent document expose les faits saillants du rapport sur les indicateurs de santé communs de l'Île-du-Prince-Édouard, paru en septembre 2002 à la suite de l'entente sur la santé conclue entre les premiers ministres en 2000. Vous pouvez vous procurer le rapport complet en communiquant avec le ministère de la Santé et des Services sociaux ou en visitant notre site Web, à www.gov.pe.ca/hss (en anglais seulement).

Le rapport présente la situation de l'Île-du-Prince-Édouard par rapport au Canada, en comparant ses données à la moyenne nationale. Les indicateurs donnent un bon aperçu de ce qui se passe actuellement. Bien qu'ils n'indiquent pas tout, avec le temps, les indicateurs révèlent des tendances qui peuvent être utilisées pour mesurer le rendement du système de santé, ainsi que l'état de santé, en faire le suivi et en rendre compte au public. Les données fournies sont les dernières compilées.

En général, les données de l'Île-du-Prince-Édouard figurant dans ce rapport sont plutôt bonnes. Il y a place à l'amélioration dans certains domaines, alors que dans d'autres, les résultats sont supérieurs à la moyenne.

Comparativement à la moyenne nationale, l'Île-du-Prince-Édouard affiche :

ÉTAT DE SANTÉ

- Une espérance de vie semblable
- Des taux semblables de mortalité infantile
- Des taux semblables de bébés de faible poids à la naissance
- Un pourcentage semblable d'habitants se disant en très bonne ou en excellente santé

RÉSULTATS EN MATIÈRE DE SANTÉ

- Des taux semblables de décès dus au cancer colorectal, du poumon ou de la prostate, ou à un accident cérébrovasculaire
- Un taux supérieur de décès dus au cancer du sein
- Un taux inférieur de décès dus à une crise cardiaque
- Un taux semblable de prévalence du diabète
- Des taux inférieurs de maladies évitables par la vaccination

QUALITÉ DU SERVICE

- Un degré de satisfaction semblable des patients quant aux services
- Un temps d'attente plus court pour les chirurgies non urgentes
- Un pourcentage semblable d'habitants ayant un médecin de famille
- Un accès immédiat plus difficile aux soins les soirs et fins de semaine
- Des taux supérieurs d'hospitalisation de personnes qui auraient pu être traitées dans la collectivité

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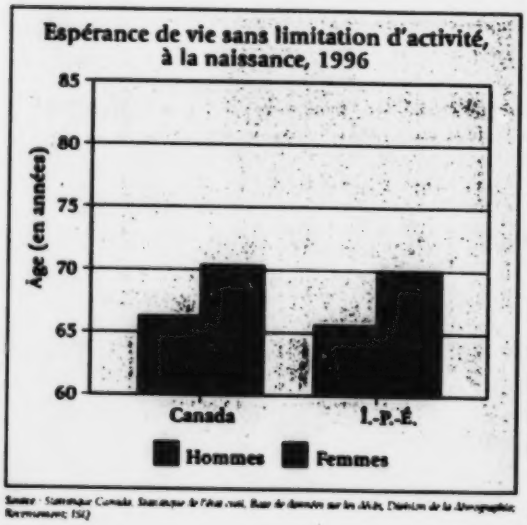
- Des taux inférieurs de nouveaux cas de tuberculose et d'infection au VIH
- Des taux semblables d'usage du tabac chez les adolescents
- Un pourcentage semblable d'habitants se disant actifs
- Des taux supérieurs d'habitants faisant de l'embonpoint
- Des taux semblables de vaccination contre la grippe

État de santé

Les indicateurs d'état de santé sont couramment utilisés pour mesurer la santé générale d'une population. Les Insulaires continuent d'obtenir de bons résultats relativement à l'espérance de vie, à l'espérance de vie sans limitation d'activité, à la mortalité infantile et à l'auto-évaluation de l'état de santé.

L'espérance de vie fait référence au nombre moyen d'années qu'une personne peut s'attendre à vivre, à partir de sa naissance.



- En 1999, l'espérance de vie des habitants de l'Î.-P.-É. était de 78,4 ans, ce qui est semblable à la moyenne nationale de 79 ans. Les femmes de l'Île avaient une espérance de vie plus élevée de 5,5 ans que celle des hommes.

L'espérance de vie sans limitation d'activité se rapporte au nombre moyen d'années qu'une personne peut s'attendre à vivre sans incapacité moyenne ou grave (au moins une limitation d'activité).

- En 1996, même si les Insulaires avaient une espérance de vie de 77,2 ans, leur espérance de vie sans limitation d'activité était de 67,6 ans, et leur espérance de vie avec incapacité moyenne ou grave, de 9,6 ans supplémentaires. Ces valeurs sont semblables à la moyenne nationale.

- En 1996, les femmes de l'Île avaient une espérance de vie sans limitation d'activité supérieure de 4,7 ans à celle des hommes.

La mortalité infantile est une mesure de la santé des enfants et fait référence au nombre d'enfants qui meurent moins d'un an après leur naissance.

- En 1999, l'Î.-P.-É. affichait un faible taux de mortalité infantile, soit 6,6 par 1 000 enfants, ce qui est près de la moyenne nationale de 5,3 et inférieur au taux moyen de 7,3 de la plupart des pays développés. Ce taux est à la baisse depuis 1980.

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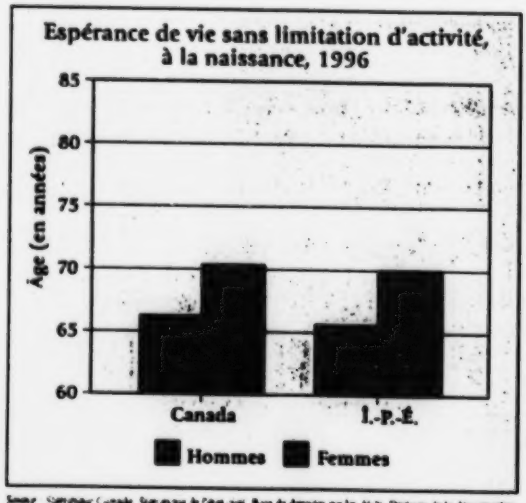

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Le taux de bébés de faible poids à la naissance fait référence au nombre de nouveaux-nés vivants pesant entre 500 et 2 500 grammes. Un tel poids peut nuire à leur survie, à leur santé et à leur développement.

- En 1999, l'Î.-P.-É. affichait un taux peu élevé de bébés de faible poids à la naissance, soit 5,2 %, ce qui est semblable à la moyenne nationale de 5,5 %. Depuis 1980, ce taux n'a pratiquement pas varié, ni à l'Île-du-Prince-Édouard ni dans l'ensemble du Canada.

L'auto-évaluation de l'état de santé indique comment les personnes perçoivent leur état de santé.

- Un grand pourcentage des Insulaires (64,4 %) ayant répondu à l'*Enquête sur la santé dans les collectivités canadiennes en 2000-2001* se disaient en très bonne ou en excellente santé, ce qui est supérieur à la moyenne nationale de 61,4 %.
- Plus d'Insulaires âgés que jeunes déclaraient être en très bonne ou en excellente santé.

Résultats en matière de santé

Les indicateurs de cette catégorie décrivent comment les services et les programmes du système de santé influent sur l'état de santé des personnes qui les utilisent. Dans cette catégorie, les résultats de l'Île-du-Prince-Édouard sont partagés.

Les taux de décès nous indiquent combien de personnes meurent chaque année en raison de certaines maladies, comme le cancer colorectal, du poumon, de la prostate ou du sein, les crises cardiaques ou les accidents cérébrovasculaires.

- Sur ces six maladies, le cancer du poumon et la crise cardiaque représentaient les principales causes de décès à l'Î.-P.-É.
- Le taux élevé de décès dus au cancer du poumon à l'Î.-P.-É. peut être attribuable à notre taux d'incidence élevé (nouveaux cas) de ce cancer.
- Les taux de décès dus au cancer à l'Î.-P.-É. sont semblables à la moyenne nationale, à l'exception du taux de décès dus au cancer du sein, qui est supérieur.
- Le taux de décès dus au cancer du poumon a augmenté passablement de 1980 à 1999, alors que les taux de décès dus au cancer colorectal, du sein ou de la prostate ont à peine varié.

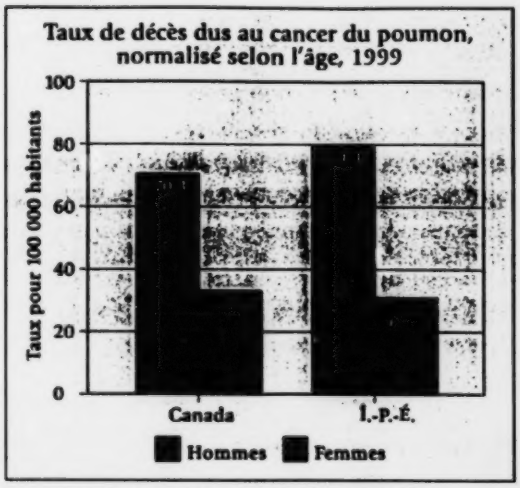
Taux de décès normalisé selon l'âge, 1999 (taux pour 100 000 habitants)

Canada	50	19,1	25,2	26,7	60,2	37,0
Î.-P.-É.	53,6	19,0	34,4	26,4	49,1	37,7

- Le taux de décès dus au cancer du poumon à l'Î.-P.É. et au Canada est passablement plus élevé chez les hommes que chez les femmes.
- Le taux de décès dus à une crise cardiaque (infarctus aigu du myocarde) à l'Î.-P.-É. est inférieur à la moyenne nationale et en baisse constante de 1980 à 1999.

- Les taux de décès dus à une crise cardiaque à l'Î.-P.-É., tout comme ceux du Canada, sont plus élevés chez les hommes que chez les femmes.

Nota : La crise cardiaque (ou infarctus aigu du myocarde) ne doit pas être confondue avec les maladies cardiaques en général, qui comprennent toutes les affections du cœur, ni avec les maladies cardiovasculaires, qui incluent les accidents cérébrovasculaires.



Source : Statistique Canada, Statistique de l'état civil et Division de la démographie (SQ)

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Amélioration de la qualité de vie

Un des principaux résultats du système de soins de santé consiste en une amélioration de la qualité de vie pour les utilisateurs du système. Des études ont révélé que la plupart des personnes subissant une arthroplastie de la hanche ou du genou connaissaient une amélioration de la qualité de vie liée à l'état de santé.

- Le taux d'arthroplasties de la hanche à l'Î.-P.-É., de 63,5 par 100 000 habitants, était semblable à la moyenne nationale, de 59,5, en 1999-2000.
- Le taux d'arthroplasties du genou à l'Î.-P.-É., de 67,1 par 100 000 habitants, est également semblable à la moyenne nationale, de 65,6.
- Contrairement à la moyenne nationale, le taux d'arthroplasties de la hanche et du genou à l'Î.-P.-É. est passablement plus élevé chez les hommes que chez les femmes.

Les taux d'incidence de maladies évitables par la vaccination (nouveaux cas pendant une année donnée) peuvent donner une idée de l'efficacité des programmes de vaccination.

- L'Î.-P.-É. affichait des taux d'incidence très faibles, avec seulement deux cas de méningococcie invasive (méningite) depuis 1993, aucun cas de rougeole et un seul cas d'infection invasive à *hemophilus influenzae B* (HIB).

Le taux de bébés de faible poids à la naissance fait référence au nombre de nouveaux-nés vivants pesant entre 500 et 2 500 grammes. Un tel poids peut nuire à leur survie, à leur santé et à leur développement.

- En 1999, l'Î.-P.-É. affichait un taux peu élevé de bébés de faible poids à la naissance, soit 5,2 %, ce qui est semblable à la moyenne nationale de 5,5 %. Depuis 1980, ce taux n'a pratiquement pas varié, ni à l'Île-du-Prince-Édouard ni dans l'ensemble du Canada.

L'auto-évaluation de l'état de santé indique comment les personnes perçoivent leur état de santé.

- Un grand pourcentage des Insulaires (64,4 %) ayant répondu à l'*Enquête sur la santé dans les collectivités canadiennes en 2000-2001* se disaient en très bonne ou en excellente santé, ce qui est supérieur à la moyenne nationale de 61,4 %.
- Plus d'Insulaires âgés que jeunes déclaraient être en très bonne ou en excellente santé.

Résultats en matière de santé

Les indicateurs de cette catégorie décrivent comment les services et les programmes du système de santé influent sur l'état de santé des personnes qui les utilisent. Dans cette catégorie, les résultats de l'Île-du-Prince-Édouard sont partagés.

Les taux de décès nous indiquent combien de personnes meurent chaque année en raison de certaines maladies, comme le cancer colorectal, du poumon, de la prostate ou du sein, les crises cardiaques ou les accidents cérébrovasculaires.

- Sur ces six maladies, le cancer du poumon et la crise cardiaque représentaient les principales causes de décès à l'Î.-P.-É.
- Le taux élevé de décès dus au cancer du poumon à l'Î.-P.-É. peut être attribuable à notre taux d'incidence élevé (nouveaux cas) de ce cancer.
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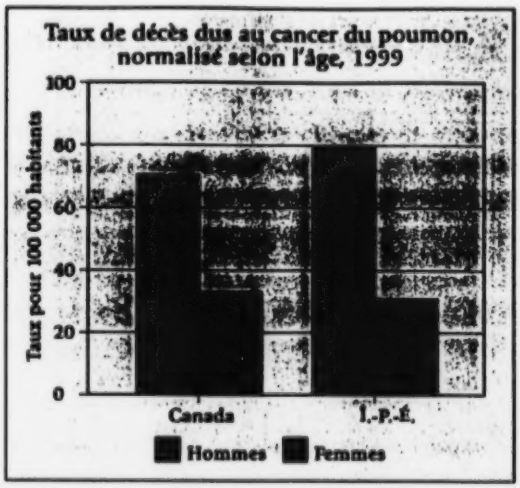

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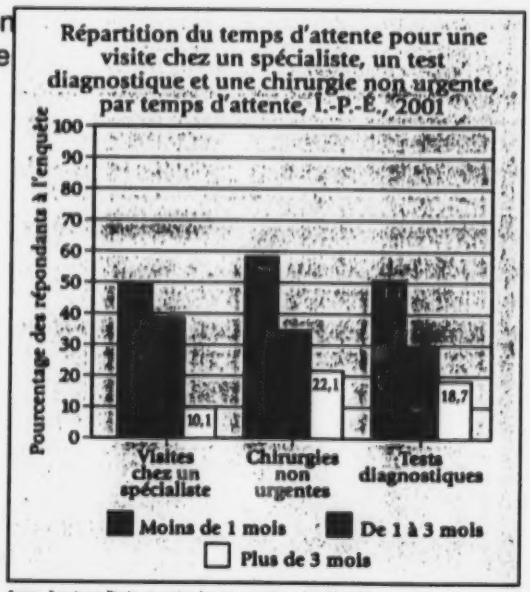
La prévalence du diabète nous donne une idée de l'importance ou du fardeau de cette maladie grave pendant une période donnée.

- Des données provisoires pour l'Î.-P.-É. et le Canada révèlent que la prévalence du diabète à l'Î.-P.-É. et au Canada était semblable de 1997-1998 à 1999-2000, avec une moyenne de 4,3 par 100 000 habitants à l'Î.-P.-É. et de 4,7 par 100 000 habitants au Canada.
- Sur une période de trois ans, le taux indique une augmentation constante de la prévalence du diabète à l'Î.-P.-É. et au Canada.
- Dans tous les groupes d'âge de l'Î.-P.-É., le taux augmente de façon constante, et le taux dans chaque groupe d'âge est constamment plus élevé chez les hommes que chez les femmes. Par exemple, le taux chez les hommes âgés entre 40 et 49 ans est de 3,1 par 100 000 habitants, alors que le taux chez les hommes âgés entre 65 et 69 ans est de 14,3 par 100 000 habitants.

Qualité du service

La qualité du service est souvent évaluée selon la perception qu'a le public de facteurs tels que le temps d'attente, la satisfaction quant aux services et l'accès aux services. Habituellement, les Insulaires parlent favorablement de la qualité des soins reçus.

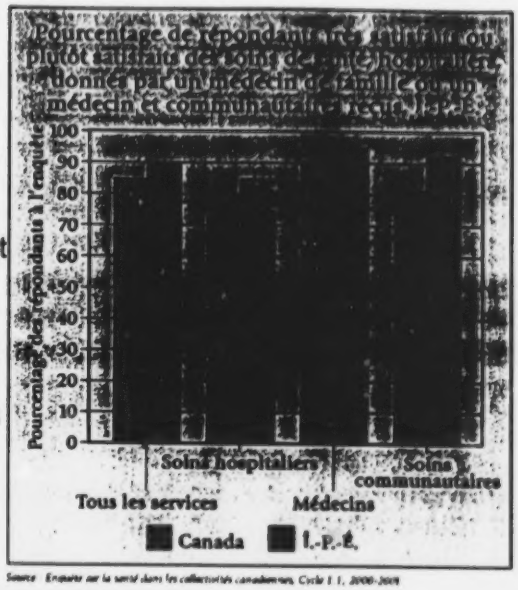


Le temps d'attente rapporté fait référence à la période de temps entre le moment où l'on détermine qu'un patient doit obtenir les services d'un spécialiste, subir une chirurgie non urgente ou être soumis à un test diagnostique, et le moment où il reçoit ce service.

- Pour ces trois types de services, en 2000-2001, de 50 % à 60 % des répondants de l'Île ont attendu moins de un mois, entre 30 % et 40 % ont attendu entre un et 3 mois et entre 10 % et 22 % ont attendu plus de 3 mois. Ces taux sont semblables aux taux nationaux.

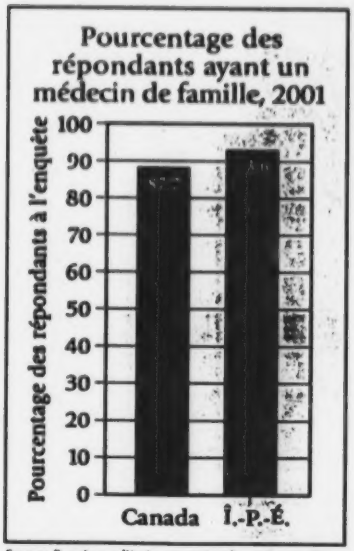
La satisfaction du patient est évaluée selon le pourcentage de la population adulte qui se dit très ou plutôt satisfaite de la façon dont divers soins de santé sont dispensés.

- En 2001, les Insulaires, tout comme les Canadiens en général, étaient satisfaits des services de soins de santé reçus.
- Le pourcentage d'Insulaires déclarant être satisfaits ou plutôt satisfaits des soins de santé reçus s'élève à 89,5 %, comparativement à la moyenne nationale de 84,6 %.
- Quant aux soins hospitaliers, communautaires et dispensés par un médecin, le pourcentage d'Insulaires satisfaits ou plutôt satisfaits dépasse la moyenne nationale de 3,6 %, avec 11,9 %.



Source : Enquête sur la santé dans les collectivités canadiennes, Cycle 1.1, 2000-2001

On croit que **l'accès à un médecin de famille** et l'établissement d'une relation continue avec un médecin de famille sont importants pour maintenir une bonne santé et assurer un accès adéquat aux services de santé.



Source : Enquête sur l'Accès aux services de santé, novembre et décembre 2001

- En 2000-2001, un pourcentage très élevé de répondants de l'Île (93,6 %) et de Canadiens en général (87,7 %) rapportaient avoir un médecin de famille.

Les taux d'hospitalisation pour les conditions propices aux soins ambulatoires, soit les affections qui peuvent être soignées au sein de la collectivité, sont une indication de l'utilisation appropriée des lits d'hôpitaux et de l'accès aux soins communautaires.

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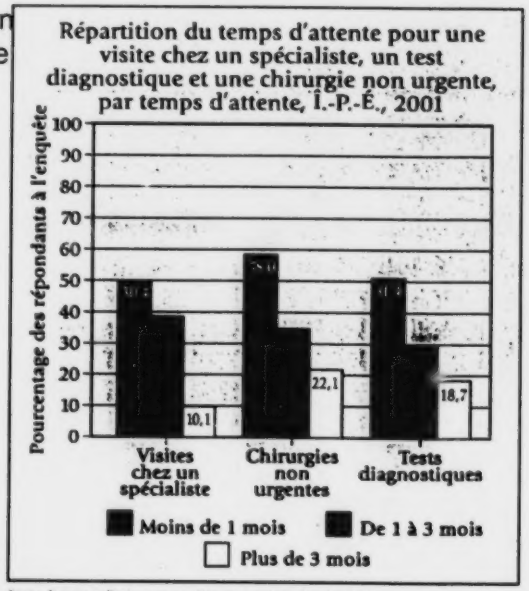

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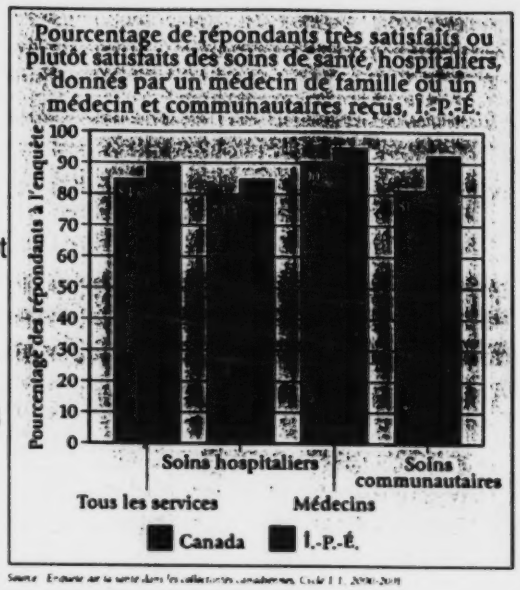

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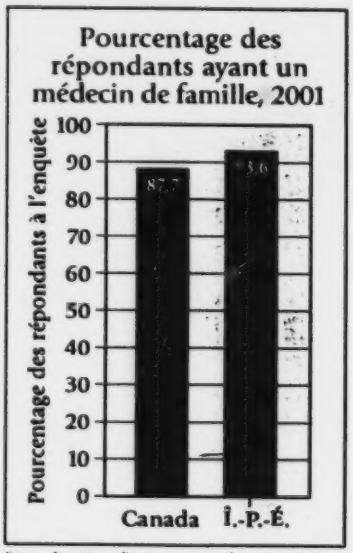

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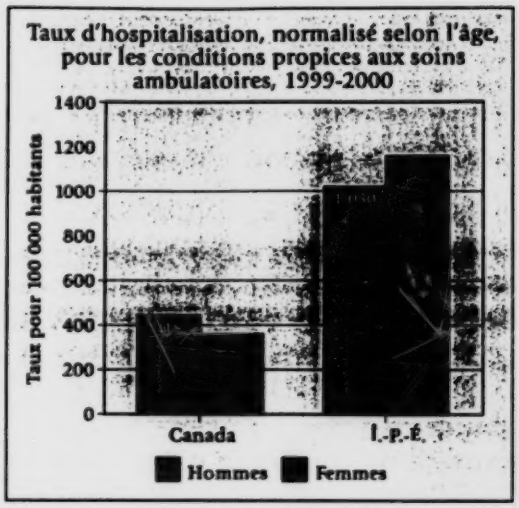
- En 1999-2000, **le taux d'hospitalisation pour les conditions propices aux soins ambulatoires**, de 1 095 par 100 000 habitants à l'Î.-P.-É., était grandement supérieur au taux national de 401 par 100 000 habitants.
- Ce taux à l'Î.-P.-É. est constamment supérieur depuis 1995-1996.



Surveillance et protection de la santé publique

Les maladies contagieuses à déclaration obligatoire et leur propagation représentent un problème de santé publique. Les taux d'incidence de ces maladies nous donnent un aperçu de l'efficacité des programmes de prévention comme la vaccination.

- En 1999, **le taux de tuberculose pulmonaire infectieuse**, de 1,5 par 100 000 habitants à l'Î.-P.-É., était très faible comparativement à la moyenne nationale de 5,9 par 100 000 habitants.
- En 2001, l'Île-du-Prince-Édouard et la Nouvelle-Écosse affichaient un faible **taux de cas d'infection au VIH déclarés**, à 0,9 par 100 000 habitants, comparativement au taux national de 7,1 par 100 000 habitants. *Nota :* Seules les données de l'Î.-P.-É. et de la N.-É. combinées sont disponibles.
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- En 2000, **le taux de chlamydiose** à l'Î.-P.-É. était de 166,3 par 100 000 habitants, ce qui est légèrement supérieur au taux national de 151,1 par 100 000 habitants. Le taux d'incidence chez les femmes entre 15 et 19 ans est particulièrement élevé.

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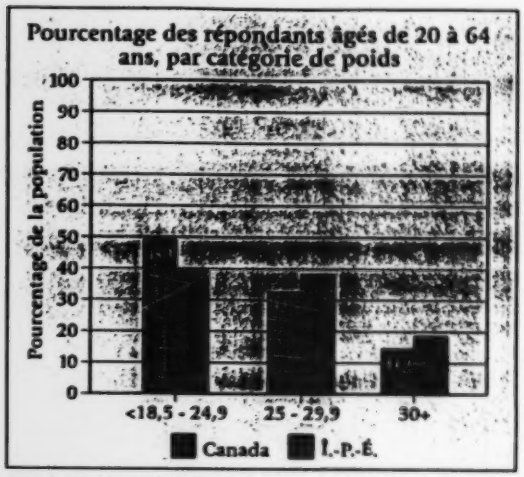
Les choix et les habitudes de vie qui présentent des risques pour la santé continuent d'être un problème important pour les Insulaires. Ces indicateurs ont été mesurés par des éléments figurant dans l'*Enquête sur la santé dans les collectivités canadiennes en 2000-2001*.

- **Usage du tabac chez les adolescents** : Environ 15 % des adolescents de l'Île se disent fumeurs, comparativement à la moyenne nationale de 18,7 %. À l'Î.-P.-É. et au Canada, les trois-quarts des répondants, environ, déclarent fumer quotidiennement.

- **Activité physique** : Seulement 19,6 % des Insulaires et 21 % des Canadiens se disent actifs. À l'Î.-P.-É., on constate une diminution du pourcentage de personnes actives avec l'âge; une baisse considérable du pourcentage peut être observée du groupe des 12 à 19 ans à celui des 20 à 34 ans.



Source : Enquête sur la santé dans les collectivités canadiennes, Cycle 1.1, 2000-2001. Enquête nationale sur la santé de la population, 1994, 1996, 1998

- **Poids corporel** : Celui-ci est calculé au moyen de l'indice de masse corporelle (IMC) déterminé à partir du poids et de la taille, tels que rapportés par les répondants.
- En 2000-2001, 39,6 % des Insulaires avaient un poids acceptable (IMC entre 18,5 et 24,9), contre 48,3 % des Canadiens.
- Le pourcentage d'Insulaires faisant de l'embonpoint s'élève à 38,1 % (IMC entre 25 et 29,9), comparativement à la moyenne nationale de 32,5 %.
- Le pourcentage d'Insulaires obèses s'élève à 18,7 % (IMC de 30 et plus), comparativement à la moyenne nationale de 14,9 %.

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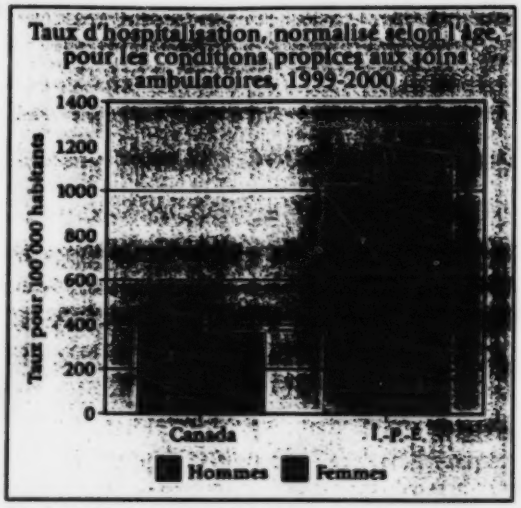

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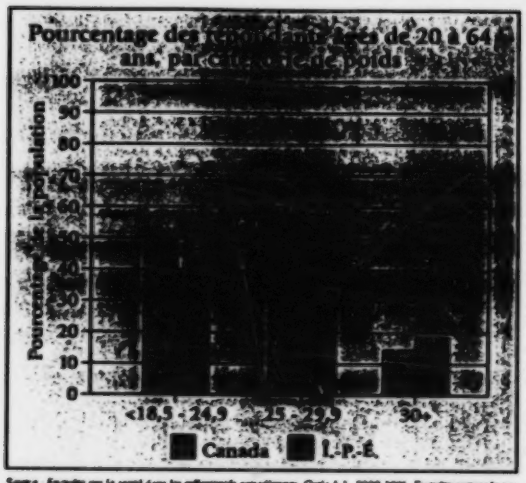
- **Usage du tabac chez les adolescents** : Environ 15 % des adolescents de l'Île se disent fumeurs, comparativement à la moyenne nationale de 18,7 %. À l'Î.-P.-É. et au Canada, les trois-quarts des répondants, environ, déclarent fumer quotidiennement.

- **Activité physique** : Seulement 19,6 % des Insulaires et 21 % des Canadiens se disent actifs. À l'Î.-P.-É., on constate une diminution du pourcentage de personnes actives avec l'âge; une baisse considérable du pourcentage peut être observée du groupe des 12 à 19 ans à celui des 20 à 34 ans.



- **Poids corporel** : Celui-ci est calculé au moyen de l'indice de masse corporelle (IMC) déterminé à partir du poids et de la taille, tels que rapportés par les répondants.
- En 2000-2001, 39,6 % des Insulaires avaient un poids acceptable (IMC entre 18,5 et 24,9), contre 48,3 % des Canadiens.
- Le pourcentage d'Insulaires faisant de l'embonpoint s'élève à 38,1 % (IMC entre 25 et 29,9), comparativement à la moyenne nationale de 32,5 %.
- Le pourcentage d'Insulaires obèses s'élève à 18,7 % (IMC de 30 et plus), comparativement à la moyenne nationale de 14,9 %.

Le rapport sur les indicateurs de santé communs de l'Île-du-Prince-Édouard contient des renseignements sur :

ÉTAT DE SANTÉ

- Espérance de vie
- Espérance de vie sans limitation d'activité
- Mortalité infantile
- Faible poids à la naissance
- Auto-évaluation de l'état de santé

RÉSULTATS EN MATIÈRE DE SANTÉ

- Taux de décès dus à un cancer, à un infarctus aigu du myocarde et à un accident cérébrovasculaire
- Taux de décès à l'hôpital dans les 30 jours suivant une crise cardiaque ou un accident cérébrovasculaire
- Taux d'arthroplasties totales de la hanche et du genou
- Taux d'incidence des cancers colorectal, du poumon, de la prostate et du sein
- Années potentielles de vie perdues en raison d'un cancer, d'une crise cardiaque, d'un accident cérébrovasculaire, de blessures accidentelles ou d'un suicide
- Taux d'incidence des maladies évitables par la vaccination
- Prévalence du diabète

QUALITÉ DU SERVICE

- Temps d'attente pour une consultation chez un spécialiste, un test diagnostique et une chirurgie non urgente
- Satisfaction des patients quant aux soins de santé, hospitaliers, donnés par un médecin et communautaires reçus
- Taux de réhospitalisation après une crise cardiaque ou une pneumonie
- Difficultés à recevoir des services de santé continus et de routine, des conseils ou des renseignements sur la santé et des soins immédiats
- Pourcentage de répondants ayant un médecin de famille
- Bénéficiaires de soins à domicile
- Pourcentage de la population recevant des services d'aide ménagère, des soins infirmiers et des soins de relève
- Taux d'hospitalisation pour des conditions propices aux soins ambulatoires
- Taux d'incidence de la tuberculose, de cas déclarés d'infection au VIH, d'infection à l'*E. coli* vérotoxinogène et de chlamydiose
- Exposition à la fumée de tabac ambiante
- Taux d'usage du tabac chez les adolescents
- Taux d'activité physique
- Poids corporel
- Taux de vaccination contre la grippe

Pour obtenir un rapport, communiquez avec le :
Ministère de la Santé et des Services sociaux
C.P. 2000
Charlottetown (Île-du-Prince-Édouard) C1A 7N8 CANADA
Téléphone : (902) 368-4900

ou visitez notre site Web à :
www.gov.pe.ca/hss (en anglais seulement)

Prince Edward Island Report on

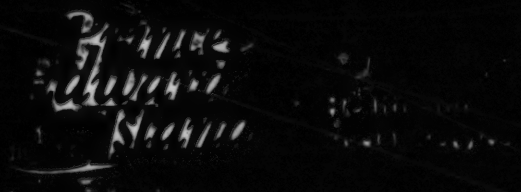
Common Health Indicators

September 2002

Health Status

Health Outcomes

Service Quality



Prince Edward Island
Common Health Indicators Report

September 2002

Prepared by the PEI Department of Health and Social Services in fulfillment of the First Ministers Agreement on Health, September 2000, for comparable indicator reporting.

September 30, 2002

I am pleased to present this first Prince Edward Island Report On Common Health Indicators.

The release of this report fulfills our commitment to the agreement made by First Ministers in 2000 to have all provinces and territories report on the health of their citizens and the performance of their health systems based on common indicators.

The report provides the public with a snapshot of our current progress, based on common indicators of health status, health outcomes and service quality. Over time, this data will be used to inform decision makers, and to report regularly to the public on where we are making progress and where further improvements are needed.

I encourage you to join with us in using this information to improve our health and health services.

Sincerely,

Jamie Ballem

Jamie Ballem
Minister of Health and Social Services

AUDITOR GENERAL

CHARLOTTETOWN

PRINCE EDWARD ISLAND

REPORT OF THE AUDITOR GENERAL ON THE RESULTS OF APPLYING SPECIFIED AUDITING PROCEDURES TO THE PRINCE EDWARD ISLAND COMMON HEALTH INDICATORS REPORT

To the Minister of Health and Social Services:

I have performed the following procedures in connection with the Prince Edward Island Common Health Indicators Report, September 2002. The Report is management's statement of the results achieved in the health indicator areas pursuant to the First Minister's Meeting Communiqué on Health issued in September 2000.

1. Verified that reported information obtained from external sources, such as Statistics Canada, the Canadian Institute for Health Information and Health Canada, agreed with the stated sources.

2. Verified that reported information originating within the Department of Health and Social Services agreed with the reports from the systems used to develop the information.

3. Tested the calculations that convert source report information into reported indicator results.

4. Verified that the health indicators were reported in accordance with the requirements contained in the Performance Indicators Reporting Committee *Plan for Federal/Provincial/Territorial Reporting on 14 Indicator Areas* as approved by the Conference of Deputy Ministers of Health.

As a result of applying the above procedures, I found no significant exceptions. However, these procedures do not constitute an audit of the health indicators and therefore I express no opinion on the Prince Edward Island Common Health Indicators Report.

Allan Moore

Allan N. Moore, CA
Acting Auditor General

Charlottetown, Prince Edward Island
September 25, 2002

September 30, 2002

Management's Responsibility for Prince Edward Island Common Health Indicators Report

Responsibility for the integrity of the attached Prince Edward Island Common Health Indicators Report (the Report) rests with the Minister of Health and Social Services. The responsibility of the Department includes maintaining systems and controls to ensure that information is objective, complete, and accurate in accordance with agreed reporting requirements developed by the Federal/Provincial/Territorial Performance Indicator Committee (PIRC) and approved by the Conference of Deputy Ministers in August 2002.

In preparing the Report, the Department relied on information provided from external parties as indicated in the Report such as Statistics Canada, the Canadian Institute for Health Information (CIHI) and Health Canada. The Department's responsibility for such information is limited to being reasonably confident that it is free of significant misrepresentation.

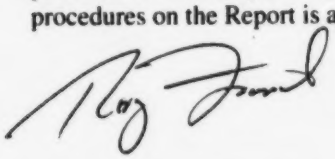
To the best of our knowledge, the information in this Report is reliable. The Report has been prepared in accordance with the following criteria, unless otherwise stated in the Report:

1. The information reported meets the requirements of the commitment of the First Ministers' Meeting Agreement on Health dated September 2000. The health indicators comply with the definitions, technical specifications and standards of presentation developed by PIRC and approved by the Conference of Deputy Ministers of Health.

2. The reported indicators fairly reflect the facts to a reasonable level of accuracy.

3. The indicator measures are defined, and their significance and limitations explained. The Report states and properly describes any departures from what was developed by PIRC and approved by the Conference of Deputy Ministers.

The Auditor General of Prince Edward Island reported on the results of applying specified auditing procedures to the Report. The report of the Auditor General on the results of applying specified auditing procedures on the Report is appended to the Report.



Rory Francis
Deputy Minister

Executive Summary

This report is the first of its kind for PEI and fulfills the province's commitment to be accountable to Islanders as per the September 2000 First Ministers Agreement on Health. The current plan is to release a report every two years. This bi-annual reporting of common health indicators will be useful for the PEI public and health system in providing information on how well we are doing and where improvements are needed. The information in this report serves to raise questions about the performance of our health system and how it effects the health status of Islanders. This information will be used to support planning and decision-making.

In September 2000, the First Ministers issued an Agreement on Health requiring clear, accountable reporting to Canadians and directed their Ministers of Health to provide comprehensive and regular public reporting beginning in September 2002. The Health Ministers established a Federal/ Provincial/Territorial committee called the Performance Indicators Reporting Committee (PIRC) which consulted extensively with all provinces and territories and relevant experts to arrive at a jointly agreed upon list of comparable measures within each of the 14 required indicator areas.

The 14 indicator areas are organized and reported under three categories: 1. Health Status Indicators; 2. Health Outcome Indicators; and 3. Quality of Service Indicators. In September 2002, PEI is able to report in all 14 indicator areas on 58 of the 67 measures. Due to issues of data availability and access PEI was not able to report on: five year relative survival rates for lung, colorectal, prostate and breast cancers; 365-day in-hospital survival for acute myocardial infarction; 180-day survival rates for stroke; and wait times for cardiac surgery, hip and knee replacement and radiation therapy.

In most cases, PEI data was compared to the national average. For all indicators the most current year of data available was reported, which in most cases was 1999 and in some cases was 2001. The focus of this report, per the First Ministers' Agreement, is on the provision of data and results to the public, not on the interpretation or meaning of the data.

PEI generally fares well in this report. There are areas where there is room for improvement and other areas where our results are better than the Canadian average. The results are summarized below.

Health Status

PEI continues to show improvement in the traditional health status indicator of life expectancy. The infant mortality rate and low birth weight rate are similar to the national average and lower than most developed countries. PEI also had a high proportion of individuals that reported that their health was very good or excellent. However, despite the relatively long life expectancy of 78.4 years, Islanders, on average, can spend approximately 10 of those years with moderate to severe disability.

Health Outcomes

In terms of indicators that are a more direct result of health services, the picture for Islanders is mixed. On the one hand, Islanders had similar death rates due to lung, colorectal and prostate cancer, heart attack and stroke compared to the Canadian average. And the PEI mortality rates for colorectal, prostate and breast cancer had remained about the same or show a slight decrease from 1990 to 1999.

Acute myocardial infarction (heart attack) mortality declined while stroke mortality has remained steady. However, the lung cancer mortality rate steadily increased, as did the lung cancer incidence rate. PEI had very low rates of new cases of vaccine-preventable diseases and a similar diabetes prevalence rate to the national average.

Quality of Service

Islanders generally spoke positively about the quality of care they received. The vast majority reported being "very" or "somewhat" satisfied with a variety of health care services. They reported having shorter median wait time for specialist physicians and non-emergency surgery compared to the Canadian average. About half waited less than one month for these services. A large number of Islanders reported having a family doctor and few had difficulty accessing routine or ongoing care or health information and advice. However, some reported difficulties accessing immediate care especially during evenings and weekends. There was also a much higher rate of hospitalization for conditions that could be treated in the community (ambulatory care sensitive conditions) compared to the Canadian average.

In terms of public health surveillance and protection, PEI had slightly lower rates of new cases of tuberculosis and reported HIV diagnoses compared to the national rates but higher rates of verotoxigenic *E. coli*. The rate of new cases of chlamydia females in the15-24 years age group was particularly high.

Lifestyle habits and choices that pose health risks continue to be a major issue for Islanders. About 15% of Island teenagers are current smokers and three quarters of these smoke daily. Less than 20% of Islanders report that they are physically active and approximately 57% are either overweight or obese. On the positive side, just over half of Islanders between 65 and 74 had been immunized for the flu.

A *Technical Appendix* detailing the methods for calculating the indicators and relevant references is available from the Results Measurement Unit, Department of Health and Social Services at 368-4955 or tpranger@gov.pe.ca.

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Health Status

Indicators in this category describe some of the common ways used to report on the overall health status of a population. These indicators have been agreed to by the Federal/Provincial/Territorial Ministers of Health.

1a. Life Expectancy

***Definition*:** The number of years a person would be expected to live on average, starting from birth based on the death rates for a calendar year. Life expectancy is not the number of years a particular newborn can actually expect to live. It is the average number of years for the entire population based on a calendar year. Individuals' circumstances vary so that, for example, if they had been a long time smoker, or had a family history of disease, their particular life expectancy would be less.

Rationale: Life expectancy is a widely used indicator of the health of a population. It is related to factors such as poverty, education levels and mortality in the first year of life. In developed countries, life expectancy is higher for women than for men. However, life expectancy is an indicator of the quantity rather than quality of life. For example, a person living longer with a serious debilitating disease may not have the same quality of life as a person living longer in good health.

Figure 1: Life expectancy at birth Canada and PEI, 1999, by sex

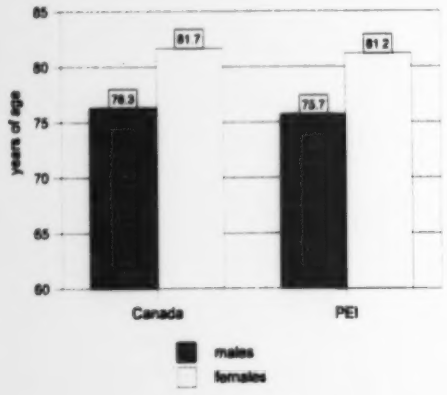
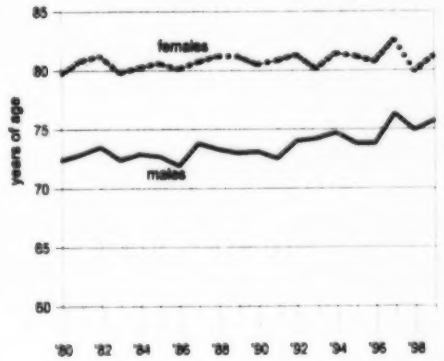


Figure 2: Life expectancy at birth PEI, 1980 -1999, by sex



Source: Statistics Canada. Vital Statistics. Death Database and Demography Division: ISQ
Exclusions: non-residents of Canada

Summary: In 1999, PEI's life expectancy rate was similar to the national rate. The rate for men and women combined for PEI was 78.4 years compared to Canada's 79.0 years. The separate rates for males and females are also very close to the national averages (see Figure1). In PEI, women appeared to live longer on average than men by 5.5 years. In the two decades up to 1999, the life expectancy rates for PEI have improved somewhat. The rates for males increased by 3.3 years and for females by 1.5 years (see Figure 2).

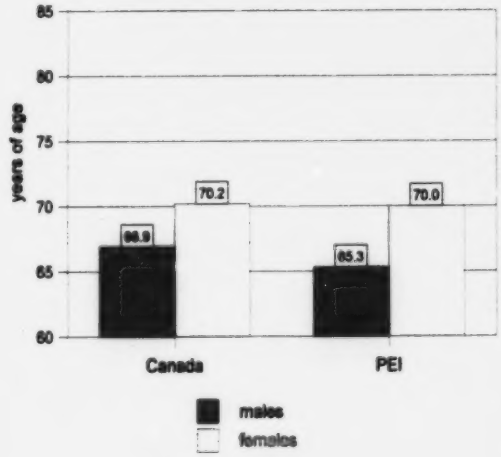
1b. Disability-free Life Expectancy (DFLE)

Definition: The number of years a person would be expected to live, on average, free of moderate or severe disability, starting from birth, based on the death rates and disability prevalence patterns for a calendar year. The 1996 rate is the most current information available. Moderate or severe disability refers to experiencing at least one activity limitation.

Rationale: Disability-free life expectancy complements conventional life expectancy measures and reflects the fact that not all years of a person's life are typically lived in perfect health. Chronic disease, frailty, and disability are more common at older ages, so that a population with a higher life expectancy may not be healthier. A major question with an aging population is whether increases in life expectancy will be associated with more older persons spending their years living with disability. If DFLE increases more rapidly than life expectancy in a population, then not only are people living longer, they are also living a greater portion of their lives free of disability.

Summary: The overall disability-free life expectancy in PEI in 1996 was 67.6 years as compared to the life expectancy of 77.2 years. Thus, though Islanders lived to 77.2 years old on average, 9.6 of those years were lived with a moderate or severe disability. Females were expected to live 4.7 years longer, disability free, than males (see Figure 3). Like life expectancy, the overall disability-free life expectancy rate for PEI was similar to the national rate of 68.6 years.

Figure 3: Disability-free life expectancy at birth Canada and PEI, 1996, by sex



Source: Statistics Canada. Vital Statistics. Death Database and Demography Division: Census: ISQ
Exclusions: non-residents of Canada: persons living on military bases or First Nation Reserves and Crown lands: residents of institutions: full-time members of the Canadian Armed Forces: residents of certain remote regions

Table 1: 95% Confidence Intervals* Disability-free life expectancy at birth, Canada and PEI, 1996, by sex

		years of age	confidence interval
Canada	males	66.9	66.8-66.9
	females	70.2	70.2-70.3
PEI	males	65.3	64.7-65.8
	females	70.0	69.3-70.6

* The 95% Confidence Interval (CI) illustrates the degree of variability associated with the rate.

2. Infant Mortality

Definition: The number of infants who die in the first year of life as a rate per 1,000 live births for a specific year.

Because PEI has a very small population, the sample sizes for indicators reported in this document are very small. As a result, even small numbers of cases can cause relatively large fluctuations/ variations in the rates of reported data from year to year. To represent a better indication of trends over time, trend data that is represented in the form of a line graph has been calculated as three-year moving averages (i.e. each year of data is averaged with both the preceding and following year). The last year in each series is a two year average.

Rationale: The infant mortality rate is a long-established measure of child health as well as the well-being of a society. It reflects the effectiveness of medical care, preventive care and the attention paid to maternal and child health, as well as broader social factors such as maternal education, smoking and deprivation. The average infant mortality rate in 1997 for 29 of 30 developed countries was 7.3 infant deaths per 1,000 live births, compared with 5.5 per 1000 in Canada (OECD Health Data 2001 CD-ROM). Among developed countries, an infant mortality rate of less than 4.0 per 1,000 is considered exceptionally good. Only Japan and Iceland had achieved such low rates by 1996. Low birth weight in Canada is the principal risk factor of infant mortality. For example, the infant mortality rate for babies that weigh less than 500 grams is considerably higher than those that weigh more than 500 grams. Thus, infant mortality for both groups is usually reported separately.

Figure 4: Infant mortality rates, by birth weight Canada and PEI, 1999

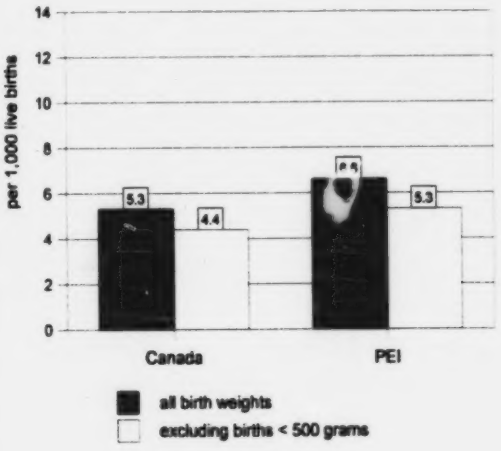
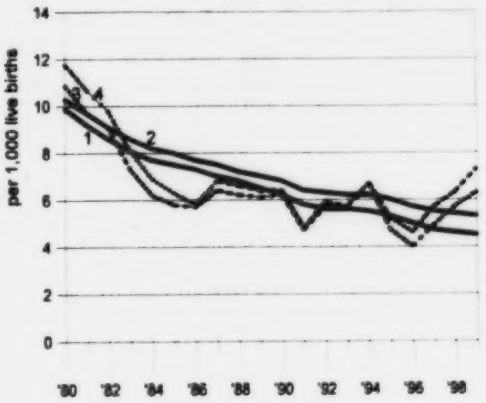


Figure 5: Infant mortality rates of all birth weights and births excluding weights <500 grams (3 year moving avg.), Canada and PEI, 1980-1999



Source: Statistics Canada. Vital Statistics. Births and Deaths data bases: ISQ
Note: Data for infants born outside the province/territory where their mother resides are included in the rates for the mother's province/territory of residence

Summary: In 1999, PEI had a low overall infant mortality rate of 6.6 per 1,000 for babies of all weights, which is similar to the national average of 5.3 (see Figure 4) and lower than the average rate of 7.3 for most developed countries. Over the two previous decades both the PEI and the national rates decreased considerably (see Figure 5).

3. Low Birth Weight

Definition: The number of live births with a birth weight between 500 and 2500 grams over the total number of live births with a birth weight greater than 500 grams in a population for a given year.

Because PEI has a very small population, the sample sizes for health indicators reported in this document are very small. As a result, even small numbers of cases can cause relatively large fluctuations/ variations in the rates of reported data from year to year. To represent a better indication of trends over time, trend data that is represented in the form of a line graph have been calculated as three-year moving averages (i.e. each year of data is averaged with both the preceding and following year). The last year in each series is a two year average.

Rationale: Low birth weight is an indicator of the general health of newborns, and a key factor affecting infant survival, health and development. Low birth weight infants are at a greater risk of dying during the first year of life, and if they survive, they have a greater risk of disability and diseases such as cerebral palsy, visual problems, learning disabilities and respiratory problems. Low birth weight is associated with poor maternal health, lifestyle and economic circumstances. Appropriate medical care and a healthy lifestyle for the mother can improve the chances that the baby will have a healthy birth weight. A low rate of low birth weight babies is a good overall sign of newborn health. The low birth weight rate in 1997 for 26 of 30 developed countries was 6.1% of live births, compared with 5.8% in Canada. (OECD Health Data 2001 CD-ROM). Among developed countries, a low birth weight rate of less than 5.0% is considered good (OECD Health Data 2001 CD-ROM).

Figure 6: Percentage of live births with low birth weight, Canada and PEI, 1999

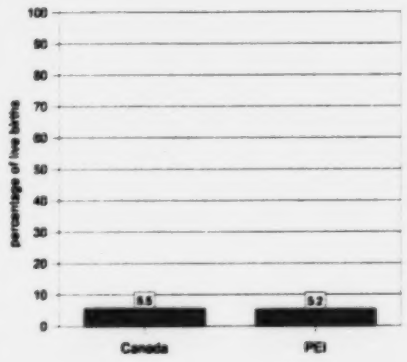
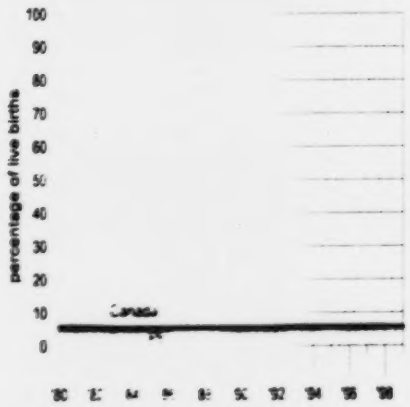


Figure 7: Percentage of live births with low birth weight (3 year moving avg.).. Canada and PEI. 1980 -1999



Source: Statistics Canada. Vital Statistics. Births database: ISQ
Exclusions: data from births with unknown birth weight and births to non-residents

Summary: In 1999, PEI had a low rate of low birth weight babies of 5.2%. similar to the national average of 5.5% and is considered good in comparison to the acceptable standard of 5.0% for most developed countries (see Figure 6). This rate remained virtually the same for PEI and Canada for the two decades since 1980 (see Figure 7).

4. Self-reported Health

Definition: Percent of the population 12 years and older, who responded to the Canadian Community Health Survey, 2000/01, who reported that their health was "very good" or "excellent".

Rationale: Self-reported health is a general indicator of the overall health status of individuals and reflects how healthy individuals feel they are. It includes what other measures may miss such as disease severity, coping skills, psychological attitude and social well-being. Self-reported health data is collected by asking individuals to rate their own health on a five point scale ranging from excellent to poor. Numerous studies have found that self-reported health can predict death rates even when more objective measures are taken into account.

Figure 8: Percent reporting "excellent" or "very good" health, Canada and PEI, 2000/01

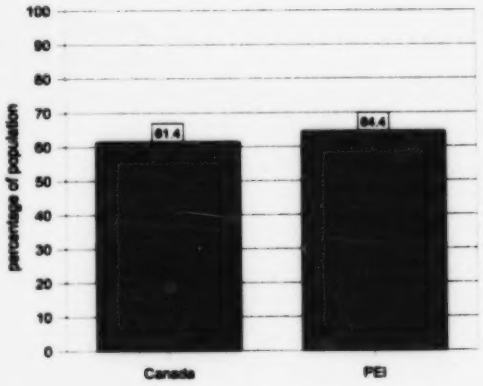
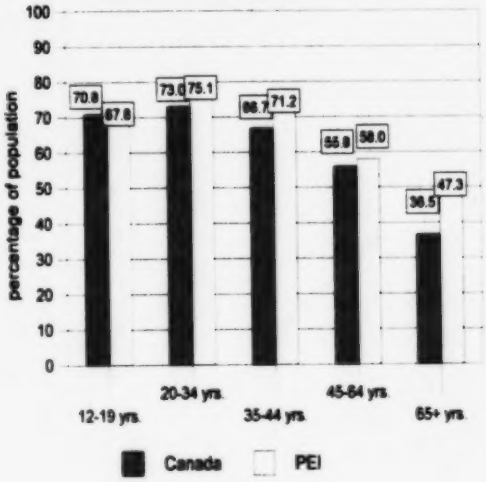


Figure 9: Percent reporting "excellent" or "very good" health, Canada and PEI, 2000/01. by age group



Source: Canadian Community Health Survey – Cycle 1.1 – 2000/01

Exclusions: non-residents of Canada; persons living on military bases or First Nation Reserves and Crown lands; residents of institutions; full-time members of the Canadian Armed Forces; residents of certain remote regions; persons under 12 years

Summary: In 2000/01, a large percentage (64.4%) of the Islanders surveyed reported their health as very good or excellent similar to the Canadian average of 61.4% (see Figure 8). However, the percent of the population who reported very good to excellent health decreased with age for both PEI and for Canada (see Figure 9).

There appeared to be no real difference in the rates of males versus females reporting very good to excellent health across all the age groups for PEI (see Figure10). The percent of the population 12 years and older self-reporting excellent or very good health did not changed significantly since 1994/95 (see Figure 11).

Figure 10: Percent reporting "excellent" or "very good" health, PEI, 2000/01, by age group

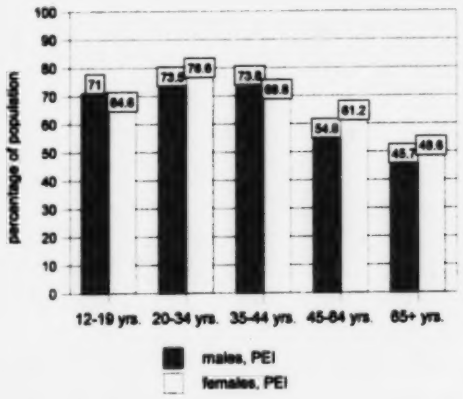
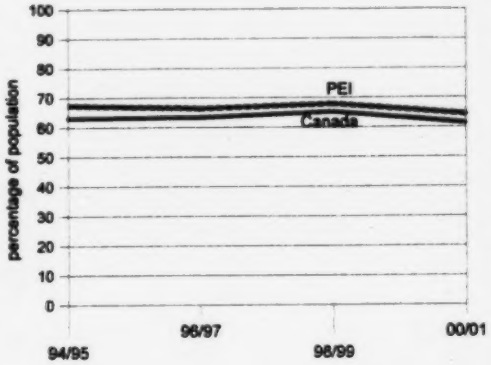


Figure 11: Percent reporting "excellent" or "very good" health, Canada and PEI, 1994/95 - 2000/01



Source: Canadian Community Health Survey – Cycle 1.1 – 2000/01; National Population Health Surveys 1994/95, 1996/97, 1998/99

Health Outcomes

Indicators in this category describe how health system programs and services affect the health status of the people who use them. It is not always possible to say with certainty that health status is due to use of a particular health program or service because there are so many other factors that affect health such as income, lifestyle, social support, etc. Where possible, indicators in this category have been selected where the link between particular health programs or services and their impact on health outcomes has been well-established through research. These indicators have been agreed to by the Federal/Provincial/Territorial Ministers of Health.

The three health outcome areas in this section are linked and focus primarily on several large disease groups: cancer, heart disease and stroke. These indicators fit together to "tell the story". For example, incidence (how often the disease occurs in a population) and mortality (death) rates show the overall burden of diseases for these conditions. Short and longer-term survival measures reflect the impact of the health system on survival for persons with these conditions. And potential years of life lost (PYLL) shows how many years of life are lost due to these conditions.

Although some health system programs and services attempt to save lives, most are designed to improve health-related quality of life. Hip and knee replacement surgery rates are proposed as surrogate indicators of improved quality of life as research has shown an improved quality of life for people who have received such surgery.

5. Change in Life Expectancy

5a. Age-standardized mortality rates for lung, colorectal, prostate and breast cancer, acute myocardial infarction (heart attack) and stroke

Definition: The number of deaths of individuals per 100,000 population, where the underlying cause of death is lung, colorectal, prostate or breast cancer, heart attack or stroke. This rate was age-standardized so the age break down was similar to that in the standard population.

Because PEI has a very small population, the sample sizes for health indicators reported in this document are very small. As a result, even small numbers of cases can cause relatively large fluctuations/ variations in the rates of reported data from year to year. To represent a better indication of trends over time, trend data that is represented in the form of a line graph have been calculated as three-year moving averages (i.e. each year of data is averaged with both the preceding and following year). The last year in each series is a two year average.

Rationale: Age-standardized cancer, heart attack or stroke death rate trends may indicate long-term success in reducing deaths from these diseases. Lower death rates may indicate success in prevention, detection, and treatment of these diseases.

5a(i). Lung cancer mortality rates

Figure 12: Lung cancer mortality rate (age-standardized), Canada and PEI, 1999, by sex

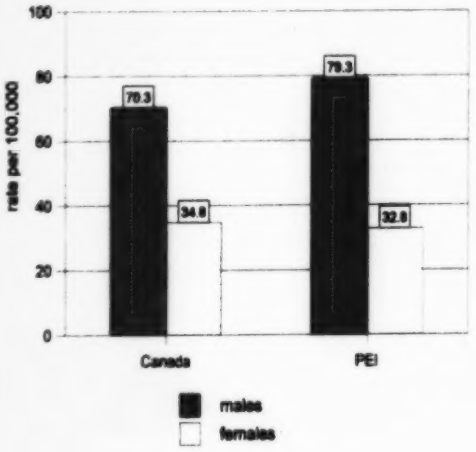
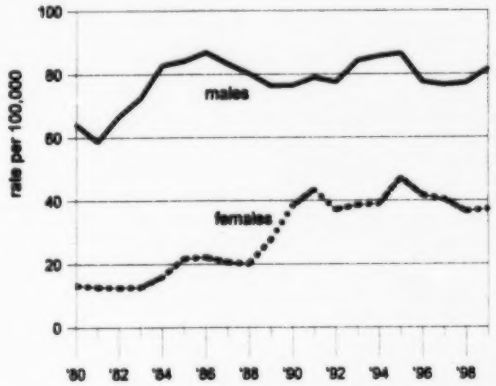


Figure 13: Lung cancer mortality rate (age-standardized & 3 year moving avg.), PEI, 1980-1999, by sex



Source: Statistics Canada. Vital Statistics, and Demography Division: ISQ
Exclusions: deaths of non-residents of Canada

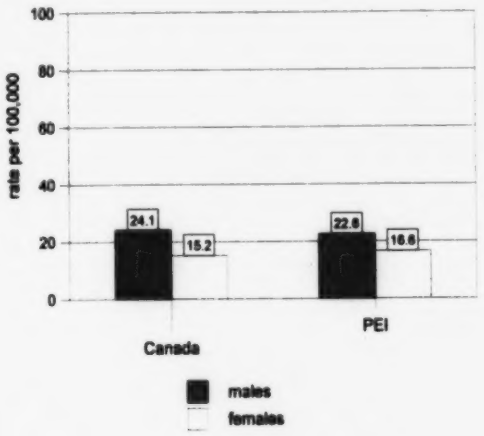
Summary: In 1999, PEI had a similar overall lung cancer death rate of 53.6 deaths per 100,000 population to the national average of 50.0 deaths. Lung cancer appears to be the leading cause of death in PEI compared to the other five conditions for mortality reported in this document, i.e. colorectal, prostate and breast cancer, heart attack and stroke. Only the acute myocardial infarction (heart attack) death rate is close at 49.1 per 100,000.

However, it has only been since1997 that the PEI lung cancer mortality rate has been higher than the heart attack mortality rate. Prior to 1997, the heart attack mortality rate was consistently higher.

In addition, in 1999, the lung cancer death rate for males was higher than that for females for both PEI and Canada (see Figure 12). There was also an increase in the death rate over the previous 20 years for PEI with a relatively greater increase for females (see Figure13). In PEI, the lung cancer mortality trend continues to increase and the acute myocardial infarction mortality trend continues to decrease (see indicator 5a(v) and Figure 21). It is important to note that heart attack should not be confused with the broader category of heart disease which includes all heart conditions, nor with cardiovascular disease which includes stroke.

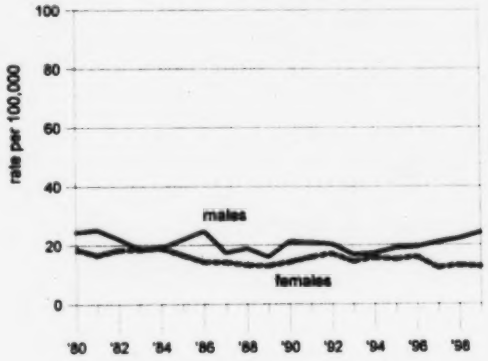
5a(ii). Colorectal cancer mortality rates

Figure 14: Colorectal cancer mortality rate (age-standardized), Canada and PEI, 1999, by sex



Source: Statistics Canada. Vital Statistics, and Demography Division: ISQ
Exclusions: deaths of non-residents of Canada

Figure15: Colorectal cancer mortality rate (age-standardized & 3 year moving avg.), PEI, 1980-1999, by sex



Summary: In 1999, the PEI overall colorectal cancer death rate of 19.0 deaths per100,000 population was virtually the same as the national average of 19.1 deaths. The colorectal cancer death rate for both PEI and Canada was the lowest of the five reported mortality rate conditions. There was little difference in rates for PEI men and women (see Figure 14). Over the previous 20 years, there was little change in the cancer death rate for PEI (see Figure 15).

5a(iii). Prostate cancer mortality rates

Figure 16: Prostate cancer mortality rate (age-standardized), Canada and PEI, 1999

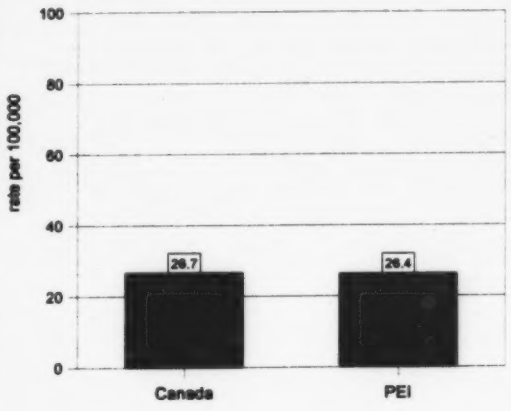
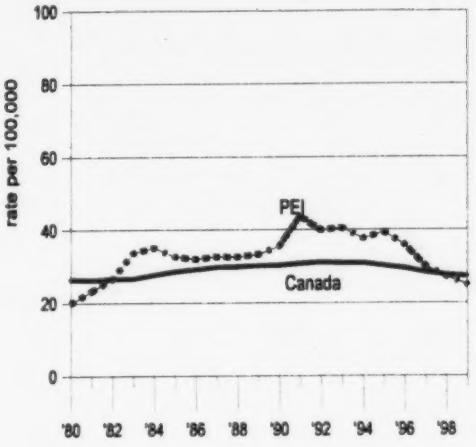


Figure 17: Prostate cancer mortality rate (age-standardized & 3 year moving avg.), Canada and PEI, 1980-1999



Source: Statistics Canada. Vital Statistics. and Demography Division: ISQ
Exclusions: deaths of non-residents of Canada

Summary: In 1999, the PEI prostate cancer death rate of 26.4 deaths per 100,000 men was virtually the same as the national average of 26.7 (see Figure16). The 20 year cancer death rate since 1980 for PEI and Canada did not change appreciably though the PEI trend fluctuated a bit more than the Canadian (see Figure 17).

5a(iv). Breast cancer mortality rates

Figure 18: Breast cancer mortality rate (age-standardized), Canada and PEI, 1999

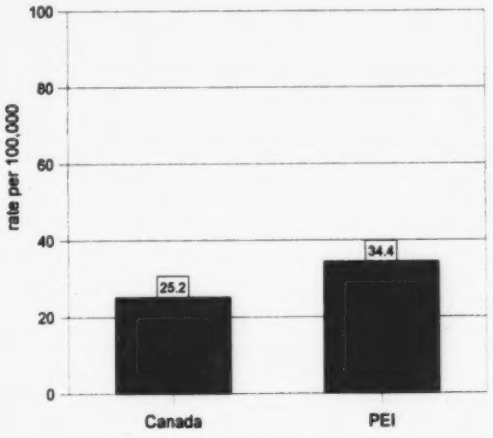
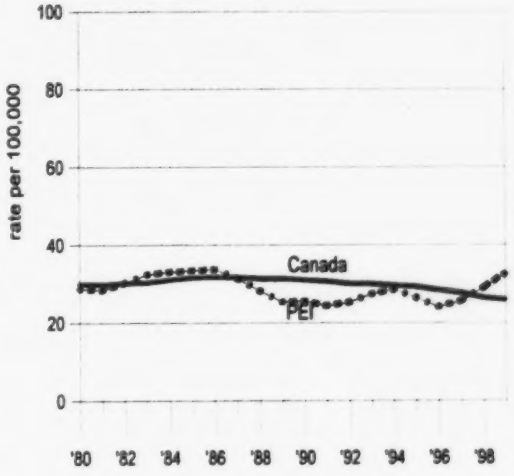


Figure 19: Breast cancer mortality rate (age-standardized & 3 year moving avg.), Canada and PEI, 1980-1999



Source: Statistics Canada. Vital Statistics. and Demography Division: ISQ
Exclusions: deaths of non-residents of Canada

Summary: The PEI breast cancer death rate of 34.4 deaths per 100.000 women in 1999 was higher than the national average of 25.2 (see Figure18). Over the previous 20 years the breast cancer death rate for PEI has risen, while the rate for Canada has been slowly declining (see Figure 19).

5a(v). Acute myocardial infarction (heart attack) mortality rates

Figure 20: Acute myocardial infarction mortality rate (age-standardized) Canada and PEI, 1999, by sex

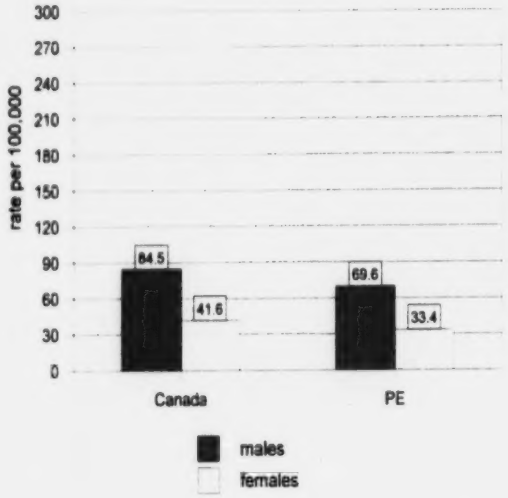
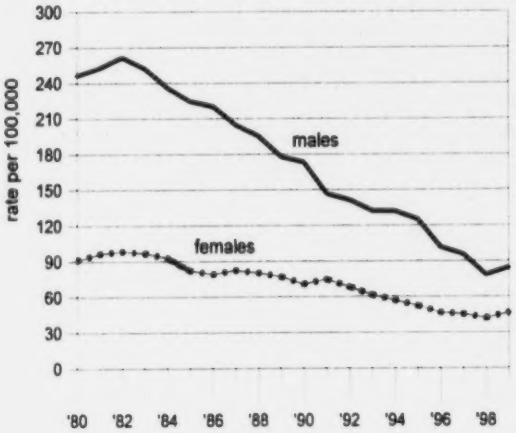


Figure 21: Acute myocardial infarction mortality rate (age-standardized & 3 year moving avg.), PEI, 1980-1999, by sex



Source: Statistics Canada, Vital Statistics, and Demography Division; ISQ
Exclusions: deaths of non-residents of Canada

Summary: PEI had an overall acute myocardial infarction (heart attack) death rate of 49.1 deaths per 100,000 population in 1999, somewhat lower than the Canadian rate of 60.2. For PEI and for Canada, the death rate for males was higher than for females (see Figure 20). The PEI rate for both males and females decreased considerably since 1980 with the rate for males having declined most sharply. The gap between male and female rates also narrowed (see Figure 21). It is important to note that heart attack should not be confused with the broader category of heart disease which includes all heart conditions, nor with cardiovascular disease which includes stroke.

5a(vi). Stroke mortality rates

Figure 22: Stroke mortality rate (age-standardized), Canada and PEI, 1999, by sex

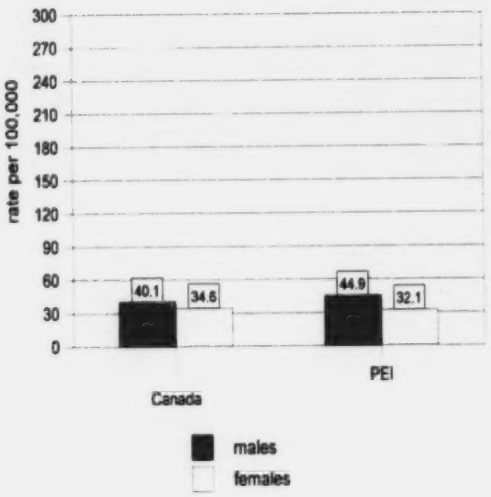
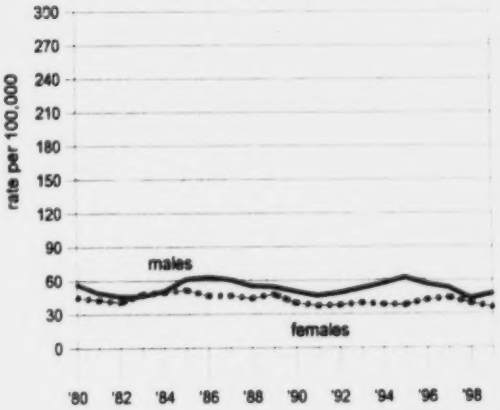


Figure 23: Stroke mortality rate (age-standardized & 3 year moving avg.), PEI, 1980 -1999, by sex



Source: Statistics Canada, Vital Statistics, and Demography Division; ISQ
Exclusions: deaths of non-residents of Canada

Summary: The 1999 stroke death rate for males and females combined for PEI was 37.7 deaths per 100,000 population which was virtually the same as the national average of 37.0. The stroke mortality rate is somewhat higher for males than for females (see Figure 22). Over a 20 year period since 1980, the PEI rate for females and males had declined (see Figure 23).

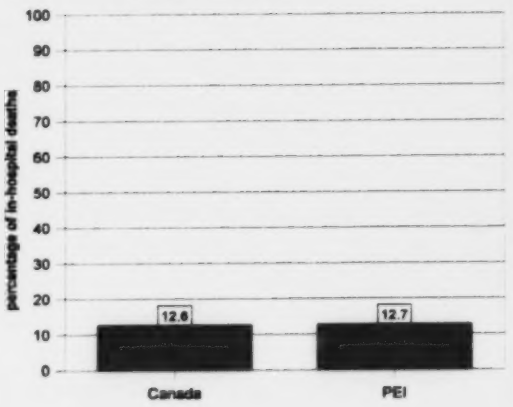
5b. Five-year age-standardized relative survival rates for lung, colorectal, prostate and breast cancer

Data from the Canadian Cancer Registry (Statistics Canada) and the Hospital Morbidity Database (CIHI) for Prince Edward Island, the Yukon Territory and the Northwest Territories are not available because of an insufficient number of cases for analysis. Cases from these areas are, however, included in national estimates.

5c. 30-day acute myocardial infarction (heart attack) in-hospital mortality rate

***Definition*:** The rate of all cause in-hospital deaths occurring within 30 days of first admission to an acute care hospital with a diagnosis of acute myocardial infarction (heart attack). The rate was risk-adjusted to take into account that different people have different risk factors for dying of heart attack, e.g. age, sex and other complicating conditions.

Figure 24: 30-day acute myocardial infarction in-hospital mortality rate (risk-adjusted), Canada and PEI. 3 year average of 1997/98 to 1999/00



Source: Hospital Morbidity Database, CIHI
Exclusions: patients less than 20 years old or older than 105 years; patients discharged alive with a total length of stay less than 3 days; transfers from another hospital; hospital records where heart attack is coded as a complication or contains an invalid Health Card number or are out of the province.

Rationale: Acute myocardial infarction (heart attack) is one of the leading causes of death in Canada. There are effective strategies for treating and preventing heart attacks. The 30-day heart attack in-hospital mortality rate can give an indication of various factors, including emergency treatments, quality of care in hospitals, primary physician care and prevention or socioeconomic factors.

Summary: The three year average 30-day in-hospital mortality rate for heart attack from 1997/98 to 1999/00 of 12.7% for PEI was similar to the national average rate of 12.6% (see Figure 24). Also the rate for PEI fluctuated somewhat over those three years (see Table 2).

Table 2: 30-day acute myocardial infarction in-hospital mortality rate (risk-adjusted) PEI, 1997/98 - 1999/00 as a percentage of all admissions with same diagnosis

1997/98		1998/99		1999/00	
rate (%)	95% CI*	rate (%)	95% CI*	rate (%)	95% CI*
13.1	8.8 - 17.5	15.0	11.0 - 18.9	10.1	6.3 - 14.0

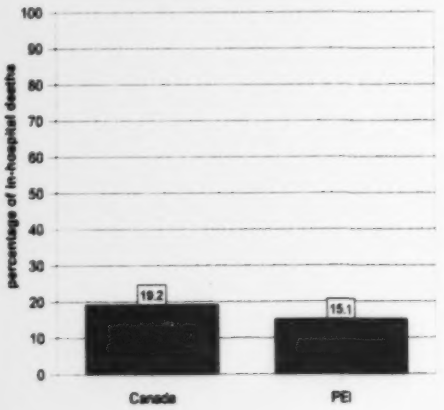
Source: Hospital Morbidity Database, CIHI
* The 95% Confidence Interval (CI) illustrates the degree of variability associated with the rate.

5d. 30-day stroke in-hospital mortality rate

Definition: The rate of all cause in-hospital deaths occurring within 30 days of first admission to an acute care hospital with a diagnosis of stroke. The rate is risk-adjusted to take into account that different people have different risk factors for dying of stroke, i.e. age, sex and other complicating conditions.

Rationale: Stroke is a major cause of death and disability in Canada. Similar to the rate for heart attacks the 30-day in-hospital mortality rate for stroke can give an indication of various factors, including emergency treatments, quality of care in hospitals, primary physician care and prevention, or socioeconomic factors.

Figure 25: 30-day stroke in-hospital mortality rate (risk-adjusted), Canada and PEI, 3 year average of 1997/98 to 1999/00



Source: Hospital Morbidity Database, CIHI
Exclusions: patients less than 20 years old or older than 105 years; patients discharged alive with a total length of stay less than 3 days; transfers from another hospital; hospital records where stroke is coded as a complication or contains an invalid Health Card number or are out of the province

Summary: The three year average 30-day in-hospital stroke mortality rate from 1997/98 to 1999/00 of 15.1% for PEI was similar to the national average of 19.2% (see Figure 25). In addition, the rate for PEI fluctuated somewhat over those three years (see Table 3).

Table 3: 30-day stroke in-hospital mortality rate (risk-adjusted), PEI, 1997/98 -1999/00, as a percentage of all admissions with same diagnosis

1997/98		1998/99		1999/00	
rate (%)	95% CI*	rate (%)	95% CI*	rate (%)	95% CI*
13.9	8.6 - 19.2	12.5	6.5 - 18.4	19.5	13.5 - 25.6

Source: Hospital Morbidity Database, CIHI
* The 95% Confidence Interval (CI) illustrates the degree of variability associated with the rate

5e. 365-day survival rates for acute myocardial infarction (heart attack)

Data from the Hospital Morbidity Databases (CIHI) is not available for PEI. Data is only available for Nova Scotia, New Brunswick, Alberta and B.C.

5f. 180-day survival rates for stroke

Data from the Hospital Morbidity Databases (CIHI) is not available for PEI. Data is only available for Nova Scotia, New Brunswick, Alberta and B.C.

6. Improved Quality of Life

One of the key outcomes of the health care system is an improved quality of life for people who use the system. Quality of life can be measured in a number of ways. One of these methods is to report on the rates of specific procedures proven to improve quality of life as approximate measures of health-related quality of life such as age-standardized rates of hip and knee replacements.

6a. Total hip replacement rate

Definition: The rate of total unilateral (one hip) or bilateral (both hips) hip replacement surgery performed on in-patients in acute care hospitals. This rate was age-standardized so the age break down was similar to that in the standard population.

Rationale: The intended outcome of most elective surgery is improved health-related quality of life. Recent research demonstrated that health-related quality of life improved substantially for the great majority of those receiving one of six different elective procedures including hip and knee replacement. Over 94% of those receiving a hip replacement reported significant improvement in pain, stiffness and overall functioning (Charles J. Wright and Yoel Robens-Paradise. *Evaluation of Indications and Outcomes in elective Surgery.* May 2001. Centre for Clinical Epidemiology and Evaluation, Vancouver Hospital and Health Services Centre.)

Figure 26: Total hip replacement rate (age-standardized), Canada and PEI, 1999/00, by sex

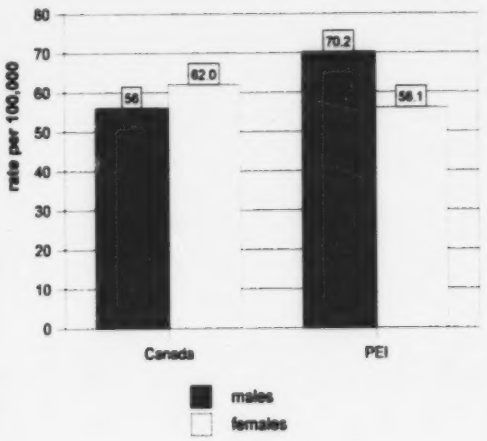
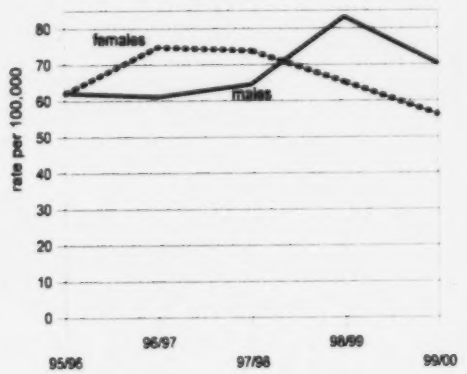


Figure 27: Total hip replacement rate (age-standardized), PEI, 1995/96 - 1999/00, by sex



Source: Hospital Morbidity Database, CIHI. Canada Census, Statistics Canada; ISQ
Exclusions: patients not treated as in-patients in acute care hospitals and those who received their surgery prior to admission

Summary: In 1999/2000, PEI had a similar rate of hip replacement of 63.5 per 100,000 population compared to the Canadian average of 59.5. The rate for Island males was considerably higher than for Canadian males but the rate of Island females was similar to that for Canadian females (see Figure 26). Over the previous four years, the hip replacement rate for both males and females have fluctuated somewhat (see Figure 27).

6b. Total knee replacement rate

Definition: The rate of total unilateral (one knee) or bilateral (both knees) knee replacement surgery performed on in-patients in acute care hospitals. This rate was age-standardized so the age break down was similar to that in the standard population.

Rationale: Same as 6a. Total hip replacement rate.

Figure 28: Total knee replacement rate (age-standardized), Canada and PEI, 1999/00, by sex

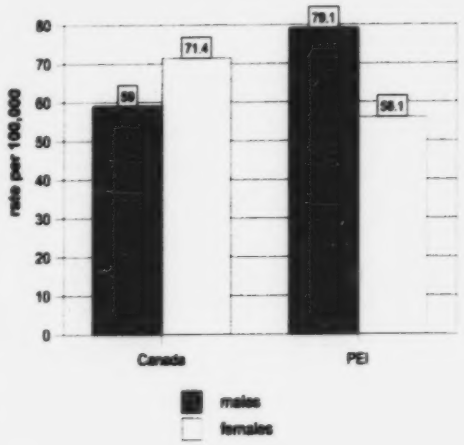
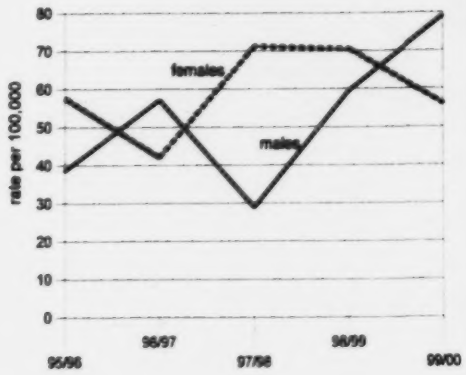


Figure 29: Total knee replacement rate (age-standardized), PEI, 1995/96 - 1999/00, by sex



Source: Hospital Morbidity Database. CIHI. Canada Census. Statistics Canada: ISQ
Exclusions: patients not treated as in-patients in acute care hospitals and those who received their surgery prior to admission

Summary: In 1999/2000, PEI had a similar overall rate of knee replacement of 67.1 per 100,000 population compared to the Canadian average of 65.6. The knee replacement rate for Island males was somewhat higher than that for Canadian males but the rate of Island females was somewhat lower (see Figure 28). Over the five year period from 1995/96 there was an increase in the overall knee replacement rate for PEI.

7. Reduced Burden of Disease, Illness and Injury

Certain disease groups and conditions create a great deal of economic burden to the individuals with the disease and to the health care system as a whole. These include lung, colorectal, prostate and breast cancer, heart attack, stroke, suicide and unintentional injury. It is therefore useful to measure how many new cases of each occur in a year (incidence) and how many potential years of life are lost due to these disease groups or conditions. In addition the quality of health during the remaining years is also crucial as can be measured by the potential years of life lost (PYLL) or by disability free life expectancy (DFLE).

7a. Age-standardized incidence rates for lung, colorectal, prostate and breast cancer

Definition: The number of newly diagnosed primary cancer cases in a given year per 100,000 population. This rate was age-standardized so the age break down was similar to that in the standard population.

Because PEI has a very small population, the sample size for health indicators reported in this document are very small. As a result, even small numbers of cases can cause relatively large fluctuations/ variations in the rates of reported data from year to year. To represent a better indication of trends over time, trend data that is represented in the form of a line graph have been calculated as three-year moving averages (i.e. each year of data is averaged with both the preceding and following year). The last year in each series is a two year average.

Rationale: Age-standardized incidence rate measures the appearance of new cases of cancer. This incidence rate is influenced by: (1) the occurence of risk factors such as smoking and; (2) the rate of detection and diagnosis of cancers through screening programs. Unfortunately it is difficult to tell which factors cause any changes in incidence of these cancers. For example, an increase in the incidence of breast cancer may be due to either a deterioration in healthy life styles or to an improvement in cancer screening.

7a(i). Lung cancer incidence rates

Figure 30: Lung cancer incidence rate (age-standardized) Canada and PEI, 1997

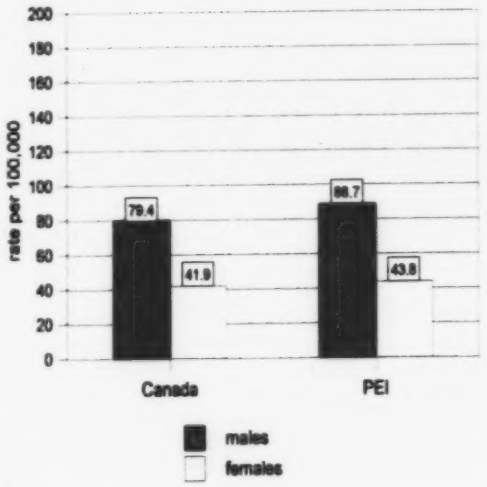
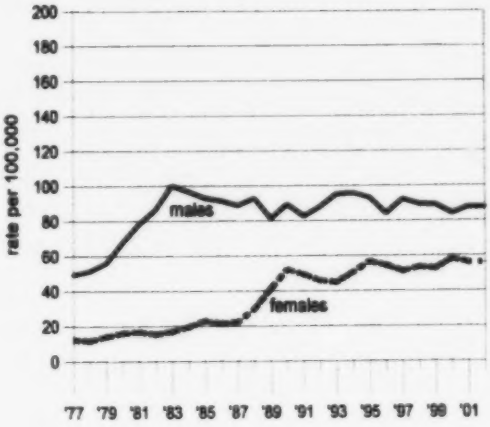


Figure 31: Lung cancer incidence rate (age-standardized & 3 year moving avg.), PEI, 1977-2002*, by sex



* 1998 - 2002 is forecast data

Source: Statistics Canada. Canadian Cancer Registry, and Demography Division: ISQ
Exclusions: non-residents of Canada

Summary: In 1997, PEI had similar overall incidence of lung cancer at 62.6 per 100,000 population to the national rate of 57.9. The rate for Island males was higher than for Island females (see Figure 30). Over the previous 20 years, the PEI lung cancer incidence rate had increased (see Figure 31).

7a(ii). Colorectal cancer incidence rates

Figure 32: Colorectal cancer incidence rate (age-standardized), Canada and PEI, 1997, by sex

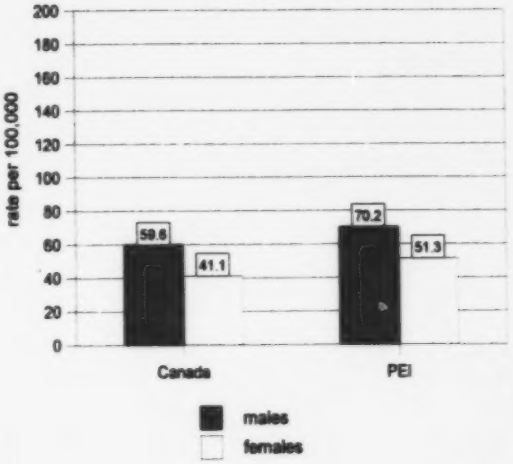
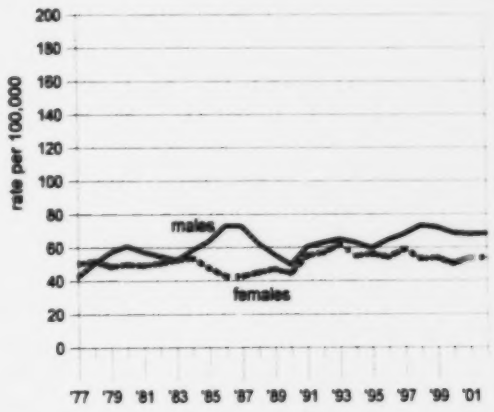


Figure 33: Colorectal cancer incidence rate (age-standardized & 3 year moving avg.), PEI, 1977-2002*. by sex



* 1998 - 2002 is forecast data

Source: Statistics Canada. Canadian Cancer Registry, and Demography Division; ISQ
Exclusions: non-residents of Canada

Summary: In 1997, the overall incidence of colorectal cancer was somewhat higher for PEI at 59.7 per 100,000 population in comparison to the national average of 49.3 (see Figure 32). Over the previous 20 years, the PEI incidence rates for both males and females had fluctuated somewhat (see Figure 33).

7a(iii). Prostate cancer incidence rates

Figure 34: Prostate cancer incidence rate (age-standardized), Canada and PEI, 1997

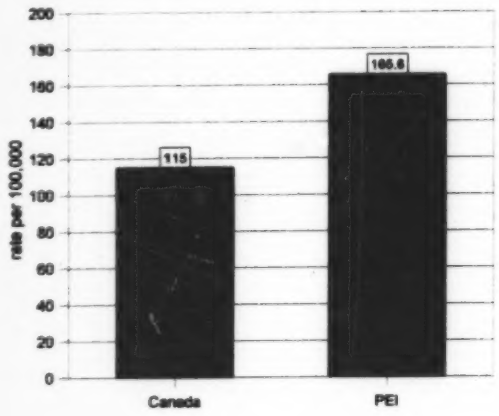
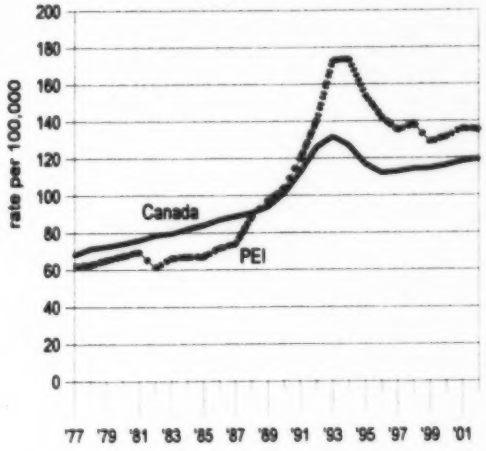


Figure 35: Prostate cancer incidence rate (age-standardized & 3 year moving avg.), PEI, 1977-2002*, by sex



* 1998 - 2002 is forecast data

Source: Statistics Canada. Canadian Cancer Registry, and Demography Division; ISQ
Exclusions: non-residents of Canada

Summary: In 1997, the incidence of prostate cancer for PEI men was somewhat higher than the Canadian average (see Figure 34). Over a 20 year period since 1977 the PEI and Canadian rates have increased considerably (see Figure 35). The PEI rate peaked in 1994 and declined toward the Canadian rate since then.

7a(iv). Breast cancer incidence rates

Figure 36: Breast cancer incidence rate (age-standardized), Canada and PEI, 1997

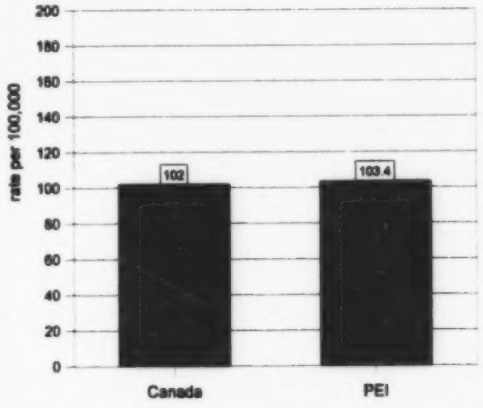
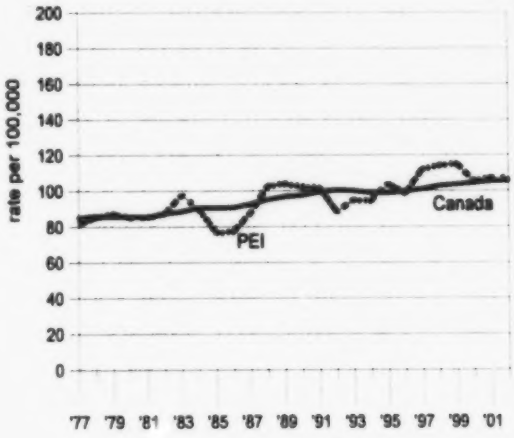


Figure 37: Breast cancer incidence rate (age-standardized & 3 year moving avg.), Canada and PEI, 1977-2002*



* 1998 - 2002 is forecast data

Source: Statistics Canada, Canadian Cancer Registry, and Demography Division; ISQ
Exclusions: non-residents of Canada

Summary: In 1997, the incidence of breast cancer for PEI at 103.4 per 100,000 women was almost the same as the Canadian average of 102.0 (see Figure 36). Over the previous 20 years the incidence rates for both PEI and Canada showed a steady increase (see Figure 37).

7b. Potential years of life lost due to lung, colorectal, prostate and breast cancer, acute myocardial infarction (heart attack), stroke, unintentional injury, and suicide

Definition: Potential years of life lost is the number of years of life "lost" when a person dies "prematurely" from any cause – defined as dying before age 75. For example, a person dying at age 25 has lost 50 potential years of life. Potential years of life lost can also be estimated for a specific cause, in which case the indicator measures the number of years of life "lost" when a person dies before age 75 due to a cause like cancer, heart attack, stroke, injury or suicide. The rates for this indicator are reported as years lost per 100,000 population.

Because PEI has a very small population, the sample size for health indicators reported in this document are very small. As a result, even small numbers of cases can cause relatively large fluctuations/ variations in the rates of reported data from year to year. To represent a better indication of trends over time, trend data that is represented in the form of a line graph have been calculated as three-year moving averages (i.e. each year of data is averaged with both the preceding and following year). The last year in each series is a two year average.

Rationale: The most widely used indicator based on death rates is life expectancy. It measures *average* expectation for length of life for an entire population, and therefore reflects both changing lengths of life for the very old and the young. Potential years of life lost is a complementary indicator focussing on mortality among the non-elderly. It reflects success in preventing premature loss of life, with its consequent loss of social and economic productivity. It is an overall indicator of population health and well being, and effectiveness of preventive programs.

7b(i). Potential years of life lost due to lung cancer

Figure 38: Potential years of life lost due to lung cancer, age 0-74, Canada and PEI, 1999, by sex

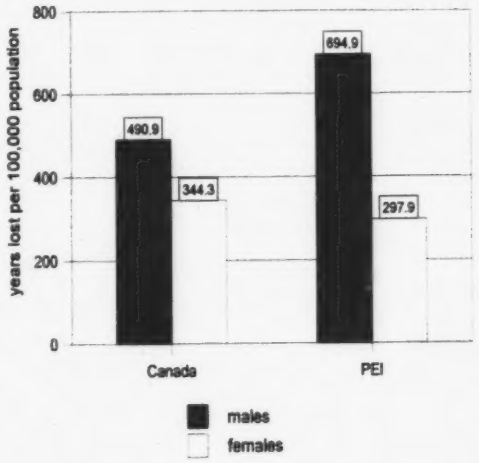
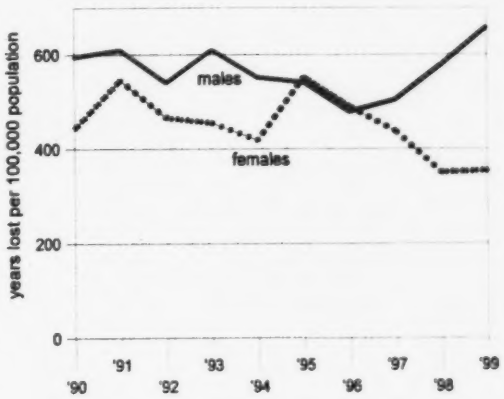


Figure 39: Potential years of life lost due to lung cancer (3 year moving avg.), age 0-74, PEI, 1990-1999, by sex



Source: Statistics Canada. Vital Statistics. Death Database and Demography Division: ISQ
Exclusions: non-residents of Canada

Summary: In 1999, PEI had a rate of potential years of life lost for lung cancer at 496.0 years per 100,000 population which was somewhat higher than the Canadian rate of 417.9. PEI's rate for men was considerably higher than for Canadian men and for Island women (see Figure 38). Over a 10 year period from 1990, there was some fluctuation but little overall change in the PEI rate for men and women (see Figure 39).

7b(ii). Potential years of life lost due to colorectal cancer

Figure 40: Potential years of life lost due to colorectal cancer, age 0-74, Canada and PEI, 1999, by sex

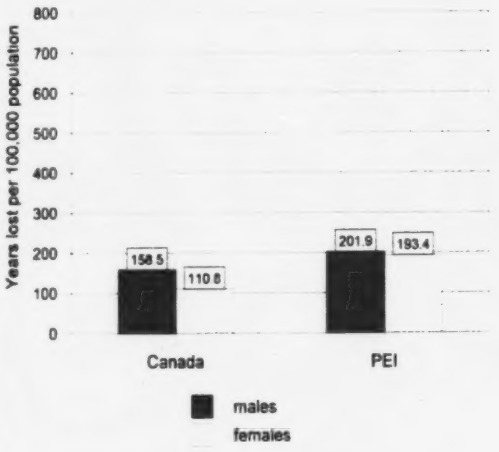
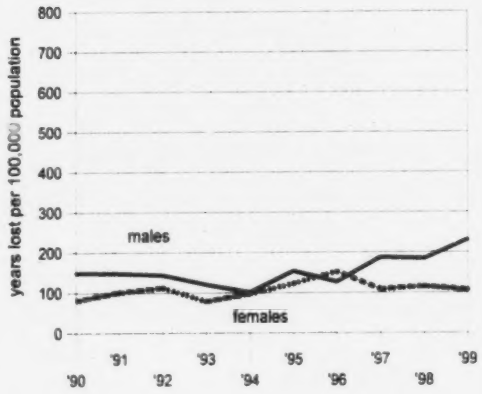


Figure 41: Potential years of life lost due to colorectal cancer (3 year moving avg.), age 0-74, PEI, 1990-1999, by sex



Source: Statistics Canada, Vital Statistics, Death Database and Demography Division ; ISQ
Exclusions: non-residents of Canada

Summary: In 1999, PEI had a somewhat higher rate of potential years of life lost for colorectal cancer at 197.6 years than the national rate of 134.7 years. There was an increase in the overall rate over time from 1990 (see Figure 41).

7b(iii). Potential years of life lost due to prostate cancer

Figure 42: Potential years of life lost due to prostate cancer, age 0-74, Canada and PEI, 1999

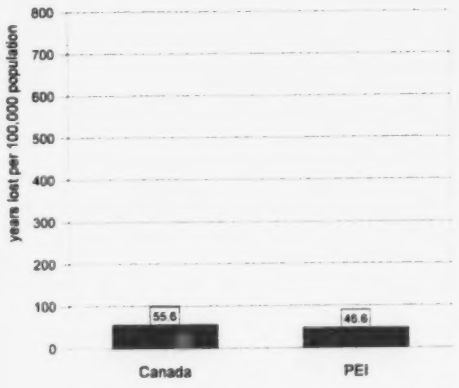
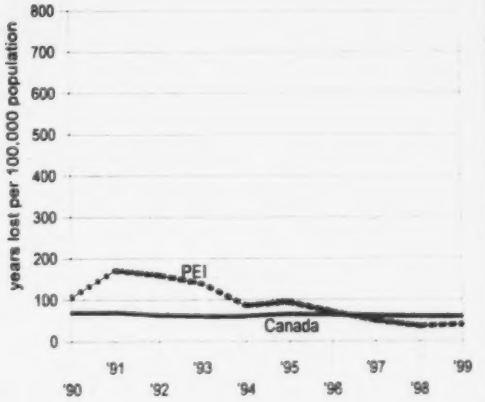


Figure 43: Potential years of life lost due to prostate cancer (3 year moving avg.), age 0-74, Canada and PEI, 1990-1999



Source: Statistics Canada. Vital Statistics. Death Database and Demography Division : ISQ
Exclusions: non-residents of Canada

Summary: In 1999, the PEI potential years of life lost rate for prostate cancer was 46.6 years per 100,000 men which was lower than the Canadian rate of 55.6 years (see Figure 42). The rate had decreased somewhat in the 10 years since 1990 whereas the average Canadian rate stayed virtually the same (see Figure 43).

7b(iv). Potential years of life lost due to breast cancer

Figure 44: Potential years of life lost due to breast cancer, age 0-74, Canada and PEI, 1999

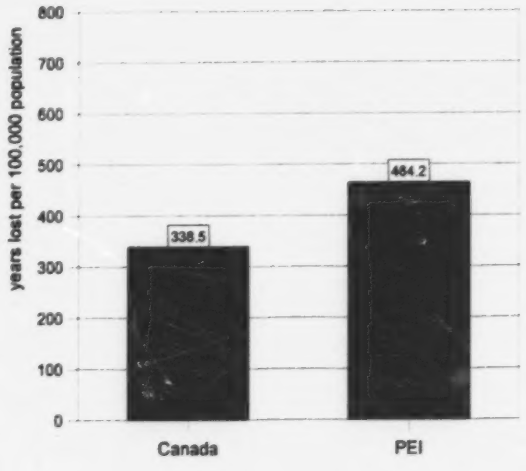
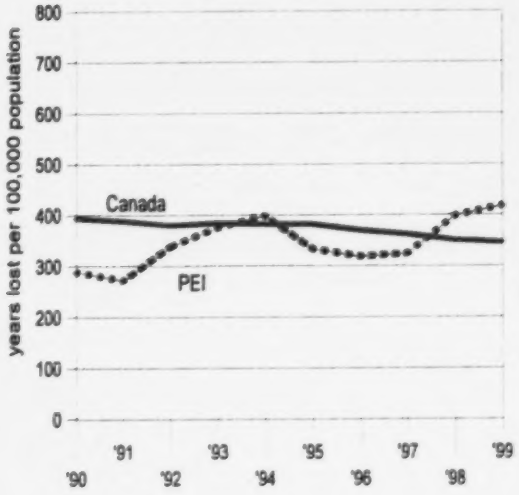


Figure 45: Potential years of life lost due to breast cancer (3 year moving avg.), age 0-74, Canada and PEI, 1990-1999



Source: Statistics Canada. Vital Statistics. Death Database and Demography Division : ISQ
Exclusions: non-residents of Canada

Summary: In 1999, the potential years of life lost rate for breast cancer for PEI was 464.2 years per 100,000 women which was higher than the national rate of 338.5 years (see Figure 44). As well, the PEI rate had increased in the previous 10 years while the Canadian average decreased slightly (see Figure 45).

7b(v). Potential years of life lost due to acute myocardial infarction (heart attack)

Figure 46: Potential years of life lost due to acute myocardial infarction, age 0-74, Canada and PEI, 1999, by sex

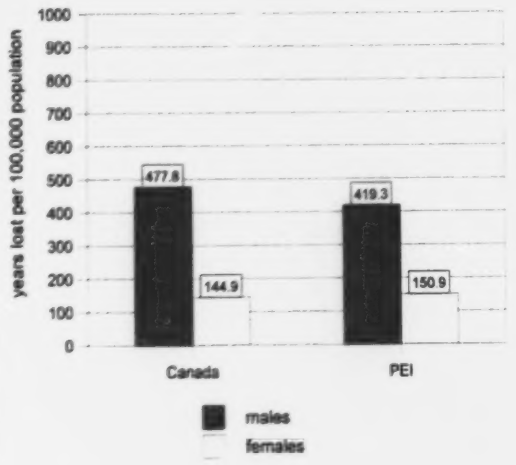
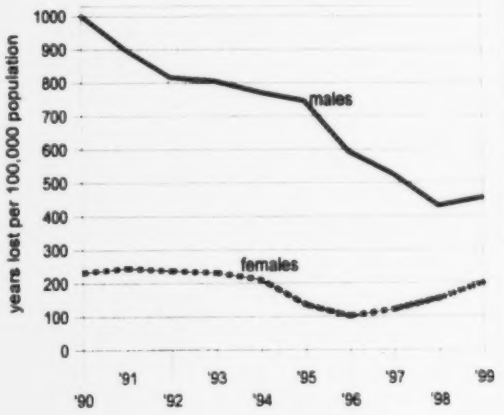


Figure 47: Potential years of life lost due to acute myocardial infarction (3 year moving avg.), age 0-74, PEI, 1990-1999, by sex



Source: Statistics Canada, Vital Statistics, Death Database and Demography Division : ISQ
Exclusions: non-residents of Canada

Summary: In 1999, the potential years of life lost rate for acute myocardial infarction (heart attack) for PEI was 284.8 years which was slightly lower that the Canadian rate of 312.1 years. Of note is the fact that the male rate for both PEI and Canada was considerably higher than that of Island or Canadian females (see Figure 46). However, the PEI rate for men decreased considerably over the previous 10 years (see Figure 47).

7b(vi). Potential years of life lost due to all stroke

Figure 48: Potential years of life lost due to all stroke, age 0-74, Canada and PEI, 1999, by sex

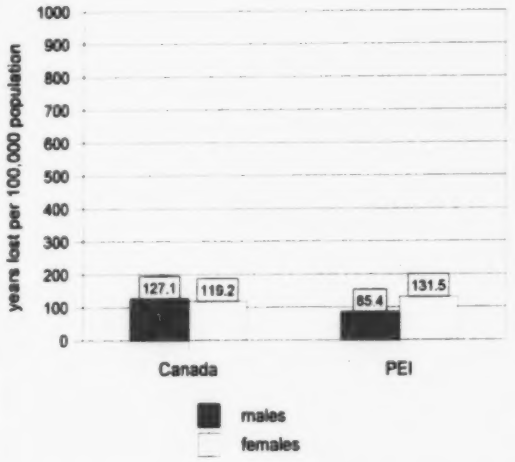
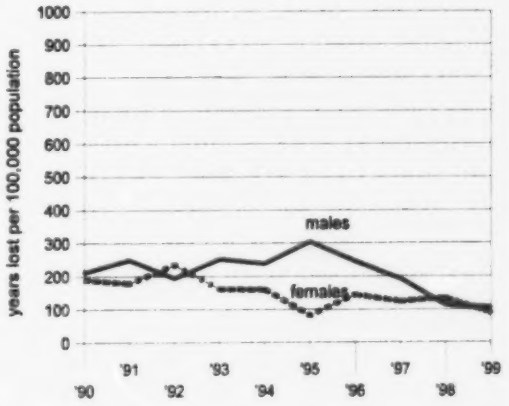


Figure 49: Potential years of life lost due to all stroke (3 year moving avg.), age 0-74, PEI, 1990-1999, by sex



Source: Statistics Canada. Vital Statistics. Death Database and Demography Division : ISQ
Exclusions: non-residents of Canada

Summary: In 1999, PEI had a potential years of life lost rate for stroke of 108.5 years per 100,000 population which was slightly lower than the Canadian rate of 123.1 years. The rate for Island women was higher than that for men whereas the rate for Canadian men and women were similar (see Figure 48). The overall rate for PEI decreased over the previous 10 years (see Figure 49).

7b(vii). Potential years of life lost due to unintentional injury

Figure 50: Potential years of life lost due to unintentional injury, age 0-74, Canada and PEI, 1999, by sex

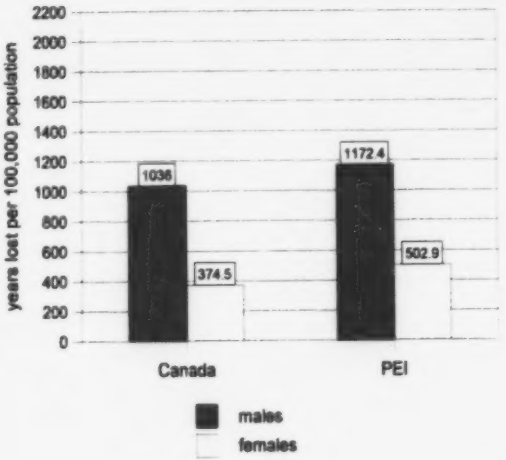
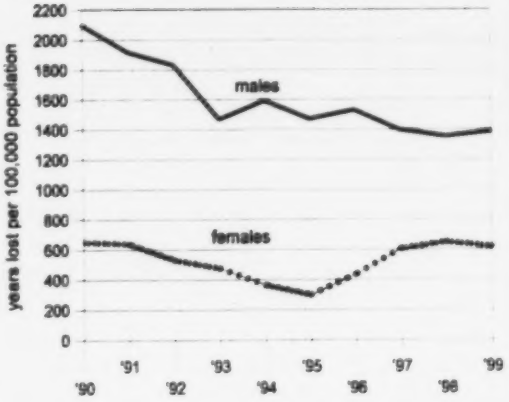


Figure 51: Potential years of life lost due to unintentional injury (3 year moving avg.), age 0-74, PEI, 1990-1999, by sex



Source: Statistics Canada, Vital Statistics, Death Database and Demography Division : ISQ
Exclusions: non-residents of Canada

Summary: In 1999, the potential years of life lost rate for unintentional injury for PEI was 837.0 years per 100,000 population which was higher than the Canadian rate of 706.6 years. Of note was the fact that the male rates for both PEI and Canada were considerably higher than the female rates (see Figure 50). The PEI rates for men had decreased considerably over the previous 10 years from 1990 (see Figure 51).

7b(viii). Potential years of life lost due to suicide

Figure 52: Potential years of life lost due to suicide, age 0-74, Canada and PEI, 1999, by sex

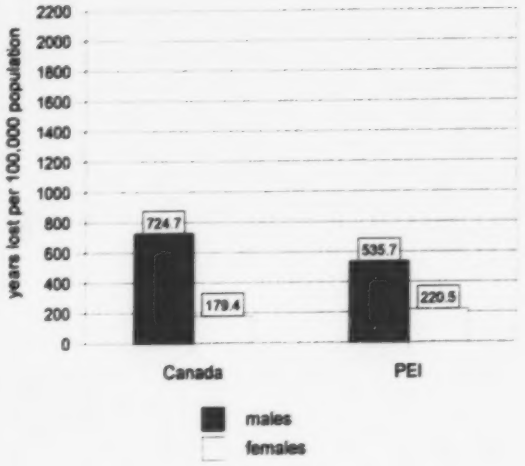
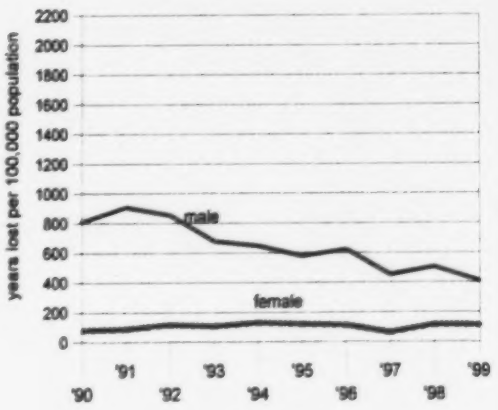


Figure 53: Potential years of life lost due to suicide (3 year moving avg.), age 0-74, PEI, 1990-1999, by sex



Source: Statistics Canada, Vital Statistics, Death Database and Demography Division : ISQ
Exclusions: non-residents of Canada

Summary: In 1999, PEI had a potential years of life lost rate for suicide of 377.8 years per 100,000 population which was somewhat lower than the Canadian rate of 453.2 years. The male rates for both PEI and Canada were considerably higher that those for females (see Figure 52). There was a decrease in the rates for PEI males over the previous 10 years whereas the rate for females was relatively constant (see Figure 53).

7c. Incidence rates of vaccine-preventable diseases

The incidence rates (new cases in a given year) of key conditions that provinces and territories are required to report to Health Canada and that can be prevented by vaccines can give a sense of the effectiveness of immunization programs. The three conditions reported here are: (i) invasive meningococcal disease (meningitis); (ii) measles; and (iii) haemophilus influenzae b (invasive) (Hib) disease.

7c. (i) Invasive meningococcal disease incidence rate

Definition: The rate of new cases of meningitis reported by year, age and serogroup (strain of the disease) for the population under 20 years of age.

Rationale: A new generation of very effective vaccines are now available against this disease which can be given to infants as young as two months of age. The National Advisory Committee on Immunization (NACI) recommends three doses of this vaccine at two, four and six months of age for routine immunization. Information on incidence rates will enable evidence-based program planning and evaluation of immunization programs. There is a high level of public interest in this disease, as well as strong potential for significant reduction in incidence over time.

Table 4: Incidence rate of invasive meningococcal disease, persons <20 years, by serogroup Canada and PEI, 1993-2001 rate per 100,000 population**

		1992	1993	1994	1995	1996	1997	1998
Canada	group C	2.4	1.4	1.3	0.8	0.7	0.6	0.2
	all other groups	1.3	1.2	1.4	1.4	1.1	1.3	0.8
PEI	group C	5.1	0	0	0	0	0	0
	all other groups	0	2.5	0	0	0	0	2.6
		1999	2000*	2001*				
Canada	all groups	1.5	1.7	2.6				
PEI	all groups	0	0	0				

Source: Notifiable Disease Reporting and Enhanced Surveillance System

* data for 2000 and 2001 are provisional

** a breakdown by serogroup for 1999-2001 was unavailable at the time of reporting

Summary

Currently PEI, like most other Canadian jurisdictions, does not routinely provide this immunization per the NACI recommendations. PEI does provide it for individuals at increased risk of infection due to a splenectomy or equivalent immune deficiency.

Since 1992, PEI only had two reported cases of invasive meningococcal disease (non-C group). These were in 1993 and 1998 and resulted in a rate of 2.5 and 2.6 per 100,000 for each of those years respectively (see Table 4). In 1992, PEI had two cases of group C which resulted in a rate of 5.1 per 100,000.

7c.(ii) Measles incidence rate

Definition: The rate of new cases of measles reported by year.

Rationale: The Pan-American Health Organization adopted the goal of measles elimination by 2000. It is also the only national goal and objective that has been adopted by all provinces and territories. Two doses of measles vaccine are required for complete protection; the first dose is given at 12 months and the second dose prior to school entry, at either 18 months or 4-6 years of age. Eliminating measles requires ongoing, enhanced surveillance and continued high immunization rates.

Table 5: Incidence rate of measles, Canada and PEI, 1980-2000 rate per 100,000 population

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Canada	56.6	9.3	4.2	3.7	15.9	10.9	57.2	9.0	2.3	40.8	3.7
PEI	0	0	0	0	0	0	0	0	0	4.6	2.3
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	
Canada	22.0	9.6	0.7	1.8	8.0	1.1	2.0	0.04	0.1	0.6	
PEI	0	0	0	0	0	0	0	0	0	0	

Source: Notifiable Disease Reporting and Enhanced Surveillance System

Summary: PEI instituted an immunization program including the second dose for measles in 1997. PEI had only 9 cases of measles reported in the 20 year period from 1980. Canada as a whole had a fluctuating, yet gradually declining rate over the same period from 56.6 per 100,000 in 1980 to 0.6 in 2000 (see Table 5).

7c. (iii) Haemophilus influenzae b (invasive) (Hib) disease incidence rate in children

Definition: The rate of new cases of haemophilus influenzae b (invasive) (Hib) reported by year in children under 5 years.

Rationale: Invasive haemophilus influenzae b was the most common cause of bacterial meningitis and a leading cause of other serious invasive infections in children prior to the introduction of Hib vaccines. Vaccine preventable cases are now rare. Four doses of the vaccine are given in combination with diphtheria, pertussis, tetanus, and polio before the age of 2 years.

Table 6: Incidence rate of haemophilus influenzae b (invasive) disease in children under 5 years Canada and PEI, 1990-2000 rate per 100,000 children under 5

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000*
Canada	16.6	9.6	10.4	3.3	1.1	1.1	1.2	1.6	0.8	0.8	0.7
PEI	30.7	0	0	0	10.6	0	0	0	0	0	0

Source: Notifiable Disease Reporting and Enhanced Surveillance System
* data for 2000 are provisional

Summary: PEI started the four dose schedule for this vaccine in 1992. PEI has only had 4 reportable cases of haemophilus influenzae b (invasive) disease from 1990 to 2000, with 3 cases in 1990 (30.7 per 100,000 children under 5) and 1 case in 1994 (10.6 per 100,000 children under 5). The Canadian incidence rate for this disease declined rapidly over that period of time (see Table 6).

7d. Prevalence of diabetes

Definition: The proportion of individuals in the population aged 20 years or over, with diabetes at a given time.

Rationale: The prevalence of diabetes gives an idea of the burden of this disease at a given time and is widely used in public health monitoring and planning. Prevalence estimates are based on data from the National Diabetes Surveillance System (NDSS). A case of diabetes is based on hospital discharge and physician billing data. The NDSS is a new system and, with the first years of data, rising prevalence may in part be due to the incomplete detection of all existing cases when only two or three years are available; it is expected that up to five years of complete data will be needed to ensure that all those with diabetes prior to system implementation have been appropriately classified. All prevalence estimates based on this early NDSS data are to be considered provisional.

Figure 54: Prevalence of diabetes (age-standardized), Canada and PEI, 1997/98-1999/00***

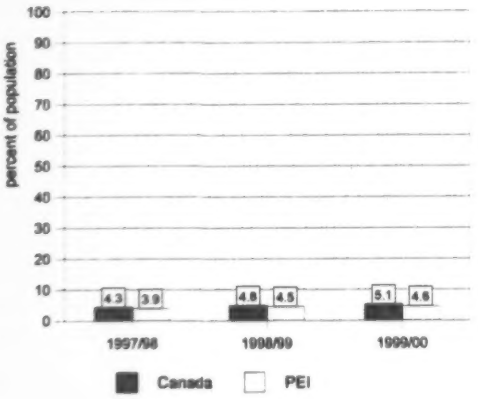
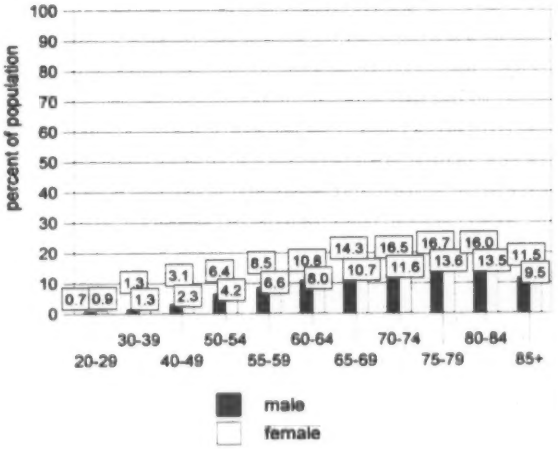


Figure 55: Prevalence of diabetes (age-standardized), PEI, 1998/99*, by age group and sex



Source: National Diabetes Surveillance System
Exclusions: persons not insured at some time during the fiscal year;
persons under 20 years; data for Canada excludes New Brunswick, Newfoundland, Nunavut and NWT
* data from 1998/99 and 1999/00 are provisional as there is not yet a complete 730 days follow-up available for these years
** any comparisons with the Canadian average should be made with caution

Summary: The prevalence of diabetes in both PEI and Canada were similar across the three years from 1997/98 to 1999/00 (see Figure 54). In terms of age and sex differences, the 1998/99 data for PEI indicates a small but steady increase in the prevalence of diabetes from age 20 to 79 with little difference between males and females (see Figure 55).

Quality of Service

Indicators in this category reflect several aspects of health service quality such as appropriateness, effectiveness, accessibility and acceptability of services. The indicators do not address all dimensions of service quality such as efficiency and safety primarily due to the limitations of existing data. These indicators have been agreed to by the Federal/Provincial/Territorial Ministers of Health.

8. Waiting Times for Key Diagnostic and Treatment Services

Health care systems have a role in achieving reasonable wait times for services by ensuring effective management of wait lists and operating room schedules, effective bed utilization strategies, and appropriate budget allocation for prevention, treatment and follow-up care. Where available provinces and territories will use their own data to report on wait times for cardiac surgery, hip and knee replacement surgery, and radiation therapy for breast and prostate cancer. PEI will only be reporting on survey-based wait time information for specialist physician services, elective surgery and diagnostic services.

8a. Wait times for cardiac surgery

Cardiac surgery is not performed in PEI. Thus, there is no data available on in-province wait times.

8b. Wait times for hip and knee replacement surgery

Provincial wait time data for hip and knee replacement surgery is not readily or easily accessible. Thus, PEI will not be reporting on this indicator for September 2002. Hip and knee replacement surgery is performed in one hospital on PEI, the Queen Elizabeth Hospital, where surgical wait lists are collected by surgeon and not by procedure. Therefore, while it is possible to determine how long the wait list is for a surgeon, it is not possible to determine how long an individual is required to wait for a particular surgery.

8c. Wait times for radiation therapy

Provincial wait time data for radiation therapy is not readily or easily accessible. Thus, PEI will not be reporting on this indicator for September 2002. Radiation therapy is performed in one hospital on PEI, the Queen Elizabeth Hospital.

8d. Reported wait times for specialist visits, diagnostic tests, and non-emergency surgery

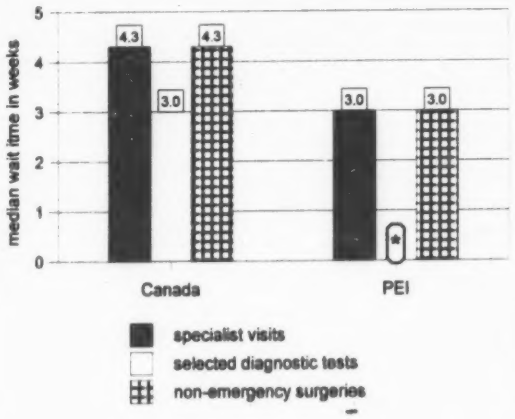
Self-reported wait times are reported on the following indicators, based on results from a supplement to the Canadian Community Health Survey called the Health Services Access Survey: median wait times for specialist physician visits, diagnostic services, and surgery; and the distribution of wait times for these services. The survey was conducted in the fall of 2001 with a random stratified sample of respondents 15 years and over.

8d(i). Reported median wait time for specialist physician visits, diagnostic services and non-emergency surgery

Definition: Wait time refers to the length of time, in weeks, between the patient being referred for a specialized service and actually receiving the service, during the 12 months prior to the survey as reported by the respondents. The median is the middle wait time where half the respondents waited less and half waited longer.

Specialist physician visits include visits for a new illness or condition only; diagnostic tests include non-emergency MRIs, CT scans and angiographies only; surgery includes only non-emergency cases.

Figure 56: Median waiting times for specialist physician visits, diagnostic tests and non-emergency surgery, Canada and PEI, 2001



Source: Health Services Access Survey – Nov-Dec 2001
Exclusions: patients who have not yet received the service; persons less than 15 years of age; persons living on First Nation Reserves and on Crown lands; residents of institutions; full-time members of the Canadian Armed Forces; residents of certain remote regions
Note: Interpret with caution-coefficient of variation between 16.6% and 33.3%: for PEI - specialist visits, non-emergency surgeries; for Canada - selected diagnostic tests
* Data not reported because coefficient of variation greater than 33% or number of observations too small to produce estimate.

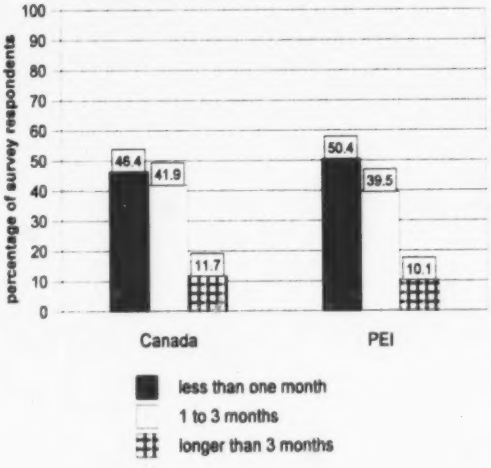
Summary: PEI respondents reported a shorter reported median wait time for specialist physician visits and non-emergency surgery than the Canadian average by 1.3 weeks (see Figure 56). The median wait time for both of these types of service was three weeks. Unfortunately, PEI was unable to report on median wait times for selected diagnostic tests.

8d (ii). Distribution of reported wait times for specialist physician visits, diagnostic tests and non-emergency surgery

Definition: Wait time refers to the length of time, in weeks, between the patient being referred for a specialized service and actually receiving the service, during the 12 months prior to the survey as reported by the respondents. The distribution refers to the percent of those requiring a specialized health service across three categories: those that waited less than 1 month, between 1 to 3 months, and more than 3 months to receive the service.

Distribution of reported wait times for specialist physician visits

Figure 57: Distribution of waiting times for specialist physician visits, by length of wait time, Canada and PEI, 2001



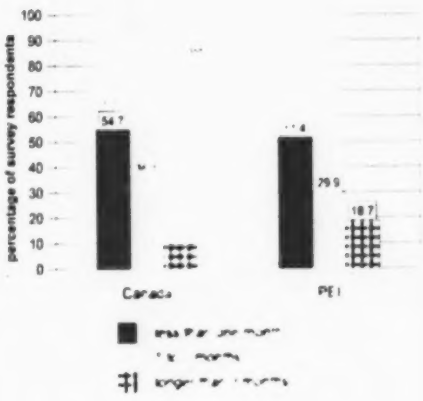
Source: Health Services Access Survey– Nov-Dec 2001
Exclusions: same as Figure 56
Note: Interpret with caution-coefficient of variation between 16.6% and 33.3% : for PEI - >3 months

Summary: Approximately half of the PEI and Canadian respondents who waited for diagnostic tests in 2001 reported that they waited for less than a month (see Figure 58). A much smaller percentage of Islanders (18.7%) and Canadians as a whole (9.1%) reported waiting for more than 3 months.

Summary: In 2001, approximately half of the PEI respondents who waited for specialist physician services reported that they waited for less than a month (see Figure 57). This rate was similar to the Canadian average of 46.4%. Only approximately 10% of both Islanders and Canadians as a whole reported waiting for more than 3 months.

Distribution of reported wait times for diagnostic tests

Figure 58: Distribution of waiting times for diagnostic tests, by length of wait time, Canada and PEI, 2001

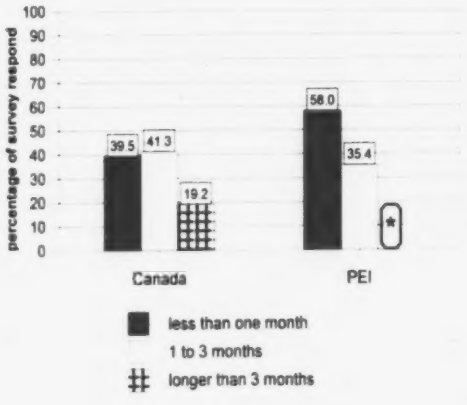


Source: Health Services Access Survey – Nov-Dec 2001
Exclusions: same as Figure 56
Note: Interpret with caution coefficient of variation between 16.6% and 33.3%: for PEI - 1-3 months, >3 months; for Canada - >3 months

Distribution of reported wait times for non-emergency surgery

Summary: Fifty-eight percent of the PEI respondents who waited for non-emergency surgery in 2001 reported that they waited for less than one month which is somewhat higher than the Canadian rate of 39.5 % (see Figure 59). Approximately half as many Islanders and Canadians reported waiting for more than 3 months for non-emergency surgery (approximately 20%).

Figure 59: Distribution of waiting times for non-emergency surgeries, by length of wait time, Canada and PEI, 2001



Source: Health Services Access Survey – Nov-Dec 2001
Exclusions: same as Figure 56
Note: Interpret with caution-coefficient of variation between 16.6% and 33.3% for PEI - 1-3 months, >3 months
* Data not reported because coefficient of variation greater than 33% or number of observations too small to produce estimate

There was no appreciable difference in the distribution of wait times across the three types of service for PEI. For all three types of service, approximately 50% to 60% of respondents waited less than one month and between 30% and 40% waited from one to three months.

9. Patient Satisfaction

Definition: Percentage of the adult population who rate themselves as either very satisfied or somewhat satisfied with the way the following services were provided: a) overall health care services received; b) services received in a hospital; c) services received from a family doctor or other physician; and d) community-based services received.

Rationale: Patient satisfaction with services is one indicator of the quality of services. The individual's assessment of the quality or care received and the satisfaction with the services was measured through items on the Canadian Community Health Survey that surveyed a representative sample of 160,000 Canadians 15 years and over. The measures apply to individuals who have received health care services over a 12-month period prior to the survey.

9a. Satisfaction with any health care services

Figure 60: Percentage very satisfied or somewhat satisfied with any health care services, Canada and PEI, 2000/01, by sex

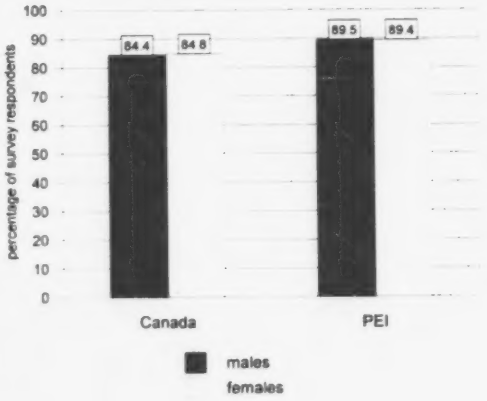
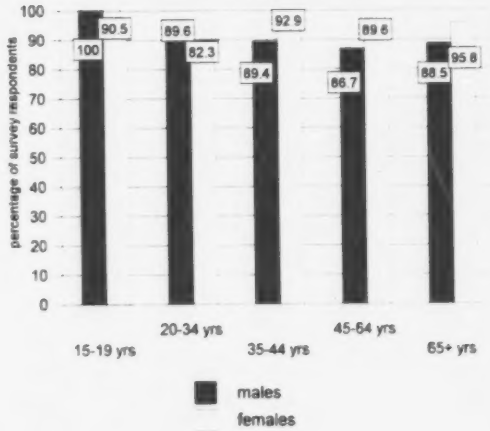


Figure 61: Percentage very satisfied or somewhat satisfied with any health care services, PEI, 2000/01, by age and sex



Source: Canadian Community Health Survey - Cycle 1.1 2000/01

Exclusions: persons less than 15 years of age, persons living on First Nation Reserves and on Crown lands, residents of institutions, full-time members of the Canadian Armed Forces, residents of certain remote regions

Note: Interpret with caution-coefficient of variation between 16.6% and 33.3% for PEI - females 15-19

Summary: Based on the 2000/01 survey results, PEI survey respondents appeared to be happy with health care services they received as 89.5% reported being somewhat or very satisfied with these services. This rate is similar to the Canadian rate of 84.6%. Male and female rates are similar for Canada and PEI (see Figure 60) and the PEI rates across the five major age categories differed little (see Figure 61).

9b. Satisfaction with hospital care

Figure 62: Percentage very satisfied or somewhat satisfied with hospital care, Canada and PEI, 2000/01, by sex

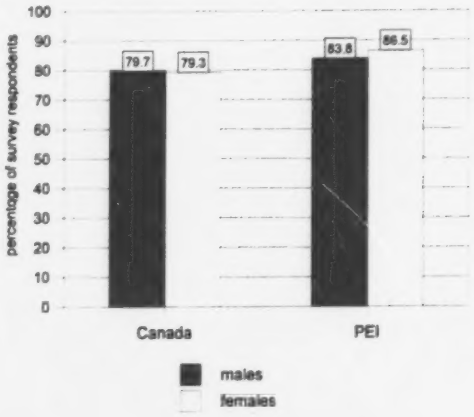
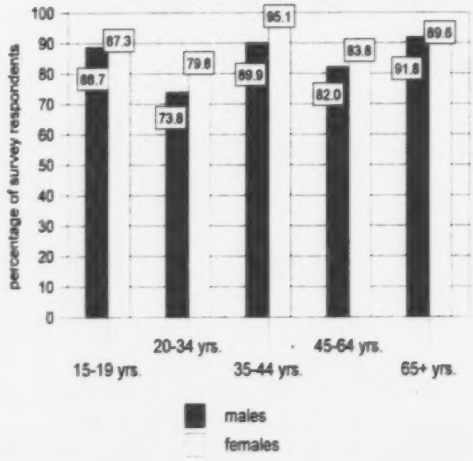


Figure 63: Percentage very satisfied or somewhat satisfied with hospital care, PEI, 2000/01, by age and sex



Source: Canadian Community Health Survey - Cycle 1.1 2000/01
Exclusions: same as Figure 60
Note: Interpret with caution-coefficient of variation between 16.6% and 33.3%: for PEI - females 15-19

Summary: The vast majority of PEI respondents were satisfied with the hospital care services they received in 2000/01. Approximately 85% reported being somewhat or very satisfied with these services which is higher than the Canadian rate of 79.5%. Rates for males and females were similar (see Figure 62). However, there were some small differences among the five major age categories. For instance, somewhat less than 80% of the 20-34 year olds were satisfied with hospital care services (see Figure 63).

9c. Satisfaction with family doctor or other physician care

Figure 64: Percentage very satisfied or somewhat satisfied with most recent family doctor or other physician care, Canada and PEI, 2000/01, by sex

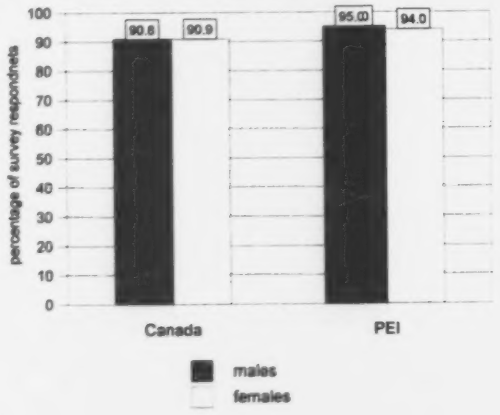
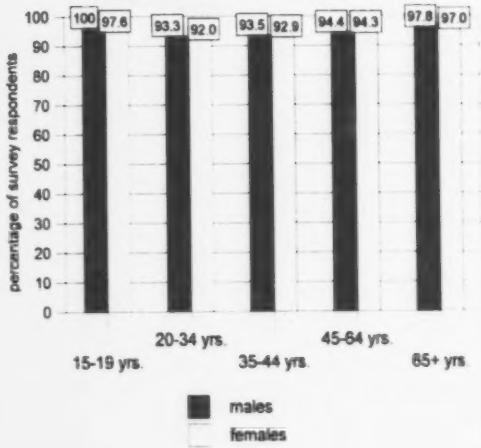


Figure 65: Percentage very satisfied or somewhat satisfied with most recent family doctor or other physician care, PEI, 2000/01, by age and sex



Source: Canadian Community Health Survey - Cycle 1.1 2000/01
Exclusions: same as Figure 60

Summary: Both PEI and Canadian survey respondents appeared to be especially pleased with the family doctor or other physician care services they received in 2000/01. Approximately 95% of Islanders and approximately 91% of Canadians reported being somewhat or very satisfied with these services (see Figure 64). There were only slight differences in the percentages of respondents who reported being somewhat or very satisfied between the sexes or among the five major age categories (see Figure 65).

9d. Satisfaction with community based health care

Community based health care included home nursing care, home based counseling or therapy, personal care and community walk-in clinics.

Figure 66: Percentage very satisfied or somewhat satisfied with most recent community based health care Canada and PEI, 2000/01, by sex

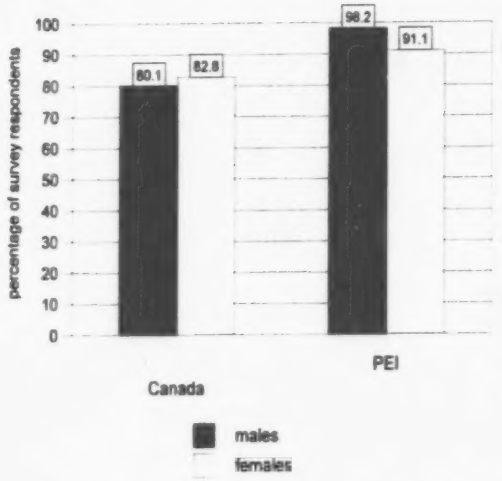
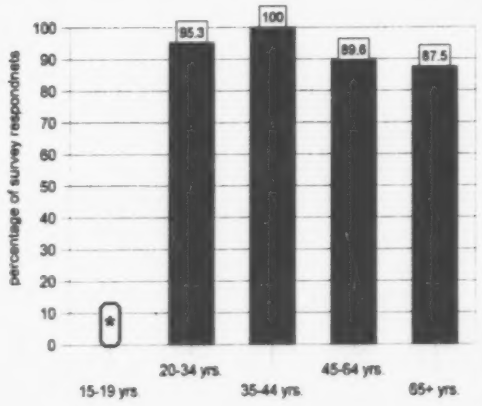


Figure 67: Percentage very satisfied or somewhat satisfied with most recent community-based health care PEI, 2000/01, by age



Source: Canadian Community Health Survey - Cycle 1.1 2000/01.
Exclusions: same as Figure 60.
Note: Interpret with caution-coefficient of variation between 16.6% and 33.3% for PEI - all rates by age group.
* Data not reported because coefficient of variation greater than 33% or number of observations too small to produce estimate.

Summary: PEI respondents were also particularly pleased with the community based health care services they received in 2000/01. Approximately 94% of Islanders reported being somewhat or very satisfied with these services as compared to 81.7% of Canadians as a whole (see Figure 66). There was little difference between Island men and Island women. Comparisons among the five major age categories for PEI should be interpreted with caution (see Figure 67).

10. Hospital Re-admissions for Selected Conditions

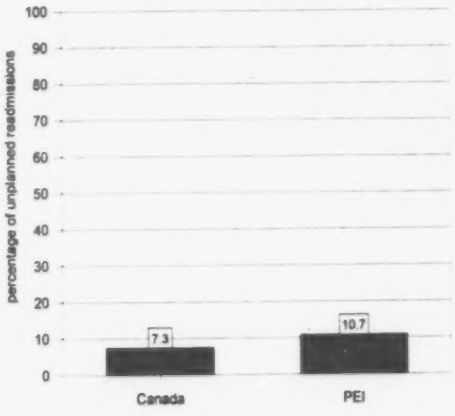
Hospital re-admission rates are one indicator of the quality of care in hospitals based on the assumption that if quality service is delivered the need for re-admission would be low. Re-admission rates for acute myocardial infarction (heart attack) and for pneumonia will be reported.

10a. Re-admission rate for acute myocardial infarction (heart attack)

Definition: The rate of unplanned re-admission following admission for acute myocardial infarction (heart attack). A case is counted as a re-admission if it is for a relevant diagnosis or procedure and occurs within 28 days after the episode of care. An episode of care refers to all continuous acute care hospitalizations including transfers. This rate is risk-adjusted to account for differences in factors such as disease severity.

Rationale: Hospital re-admission rates for selected conditions can provide one measure of the quality of care. Many factors may be related to hospital re-admission, for example: the medication prescribed at initial discharge from hospital, patient compliance with directions, the quality of follow-up care in the community, and the quality and completeness of care during initial hospitalization. Higher than normal readmission rates should lead health services managers to examine any of the following: practices in hospitals (e.g., early discharge criteria), the availability of appropriate community services, coordination between hospital and community providers, and patient education and instruction.

Figure 68: Re-admission rate (risk-adjusted) for acute myocardial infarction Canada and PEI, 3 year avg. of 1997/98 to 1999/00 rates



Source: Discharge Abstract Database, CIHI

Summary: The PEI three year average (1997/98 to 1999/00) re-admission rate for acute myocardial infarction (heart attack) was 10.7% similar to the Canadian average rate of 7.3% (see Figure 68). The PEI rate fluctuated considerably over that three year period (see Table 7).

Table 7: Readmission rate (risk-adjusted) for acute myocardial infarction (heart attack), PEI, 1997/98 -1999/00 rate (%) = percentage of unplanned re-admissions

1997/98		1998/99		1999/00	
rate (%)	95% CI*	rate (%)	95% CI*	rate (%)	95% CI*
6.6	2.8 - 10.4	15.4	12.2 - 18.7	9.0	5.6 - 12.4

Source: Discharge Abstract Database, CIHI

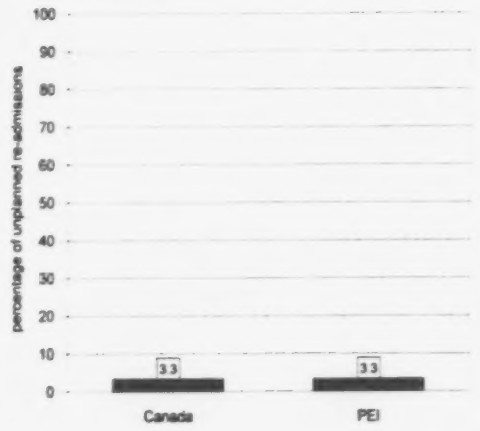
* The 95% Confidence Interval (CI) illustrates the degree of variability associated with the rate.

10b. Re-admission rate for pneumonia

Definition: The rate of unplanned re-admissions following admission for pneumonia. A case is counted as a re-admission if it is for a relevant diagnosis or procedure and occurs within 28 days after the pneumonia episode of care. An episode of care refers to all continuous acute care hospitalizations including transfers. This rate is risk-adjusted to account for differences in factors such as disease severity.

Rationale: See rationale for re-admission rate for 10a, acute myocardial infarction (heart attack).

Figure 69: Readmission rate (risk-adjusted) for pneumonia, Canada and PEI, 3 year avg. of 1997/98 to1999/00 rates



Source: Discharge Abstract Database, CIHI

Summary: Both PEI and Canada as a whole had a three year average (1997/98 to 1999/00) re-admission rate for pneumonia of 3.3% (see Figure 69). The PEI rate remained relatively stable over those three years (see Table 8).

Table 8: Re-admission rate (risk-adjusted) for pneumonia PEI, 1997/98 - 1999/00
rate (%) = percentage of unplanned re-admissions

1997/98		1998/99		1999/00	
rate (%)	**95% CI***	**rate (%)**	**95% CI***	**rate (%)**	**95% CI***
3.7	0.9 - 6.4	**2.8**	0.8-4.9	**3.5**	1.2-5.8

Source: Discharge Abstract Database, CIHI
* The 95% Confidence Interval (CI) illustrates the degree of variability associated with the rate.

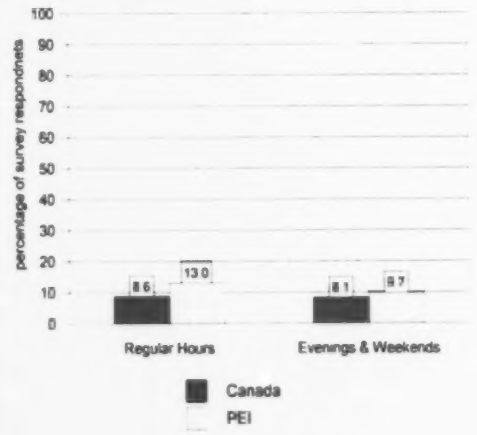
11. Access to 24/7 First Contact Health Services

The data for 24/7 first contact health services refers to three types of service: a) direct treatment services routine health care needs; b) health information and advice; and c) direct treatment services to meet immediate health care needs. The ability to obtain these services when needed is believed to be important in maintaining health, preventing more serious health problems and encouraging appropriate use of and preventing the inappropriate use of services (e.g., use of hospital emergency rooms for non-emergencies). The following indicators will be reported: the percent of surveyed individuals who experienced difficulty obtaining (a) routine or on-going health services; (b) health information or advice; or (c) immediate care for a minor health problem. As well, the percent who have a regular family doctor will be reported. The data was collected through the Health Access Survey, a supplement to the Canadian Community Health Survey.

11a. Percent who experienced difficulties obtaining routine or on-going health services

Definition: The percent of people surveyed who required routine or on-going health services for self or a family member in the 12 months prior to the survey and experienced difficulties obtaining them (a) during regular daytime hours (9am to 5pm, Monday to Friday) and (b) during evenings (5pm to 9pm Monday to Friday) and weekends (Saturday and Sunday).

Figure 70: Percentage reporting difficulties accessing routine or on-going care, by time of day, Canada and PEI, 2001



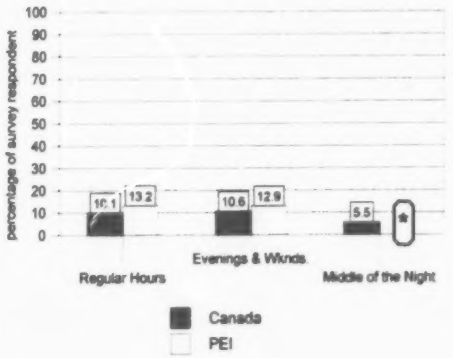
Source: Health Services Access Survey- Nov.-Dec. 2001
Exclusions: persons less than 15 years of age; persons living on First Nation Reserves and on Crown lands; residents of institutions, full-time members of the Canadian Armed Forces, residents of certain remote regions
Note: Interpret with caution-coefficient of variation between 16.6% and 33.3% for PEI - evenings & weekends

Rationale: The ability to obtain routine care when needed is believed to be important in maintaining health, preventing health emergencies and preventing the inappropriate use of services such as emergency rooms for non-emergencies.

Summary: In 2001, few PEI survey respondents reported difficulty accessing routine or on-going care. Only 13.0% had difficulties during regular daytime hours and only 9.7% had difficulties during evenings and weekends (see Figure 70). These rates were higher than Canadian rates.

11b. Percent who experienced difficulties obtaining health information or advice

Figure 71: Percentage of population reporting difficulties obtaining health information or advice, by time of day Canada and PEI, 2001



Source: Health Services Access Survey- Nov.-Dec. 2001
Exclusions: same as Figure 70
* Data not reported because coefficient of variation greater than 33% or number of observations too small to produce estimate.

Definition: The percent of people surveyed who required health information or advice for self or a family member in the 12 months prior to the survey and experienced difficulty obtaining it (a) during regular daytime hours (9am to 5pm, Monday to Friday), (b) during evenings (5pm to 9pm Monday to Friday) or weekends (Saturday and Sunday), and/or (c) during the middle of the night.

Rationale: Access to information or advice is believed to be important to maintaining health and ensuring appropriate access to health services.

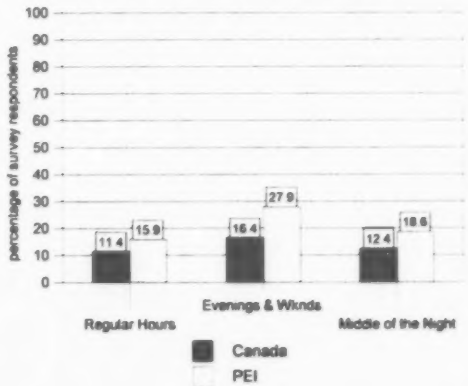
Summary: Few PEI respondents reported having difficulty obtaining health information or advice in 2001. Only 13.2 % had difficulties during regular daytime hours and only 12.9% had difficulties during evenings and weekends (see Figure 71). These rates were similar to the overall national average.

11c. Percent who experienced difficulties obtaining immediate care for a minor health problem

Definition: The percent of people surveyed who required immediate care for a minor health problem for self or a family member in the 12 months prior to the survey and experienced difficulty obtaining it (a) during regular daytime hours (9am to 5pm, Monday to Friday), (b) during evenings (5pm to 9pm Monday to Friday) or weekends (Saturday and Sunday), and/or (c) during the middle of the night. Minor health problems are those that are not emergencies.

Rationale: The ability to obtain immediate needed care for minor health problems is believed to be important in restoring health, preventing health emergencies, and preventing the inappropriate use of services.

Figure 72: Percentage reporting difficulties obtaining immediate care for a minor health problem, by time of day, Canada and PEI, 2001



Source: Health Services Access Survey- Nov.-Dec. 2001
Exclusions: same as Figure 70
Note: Interpret with caution-coefficient of variation between 16.6% and 33.3% : for PEI - middle of the night

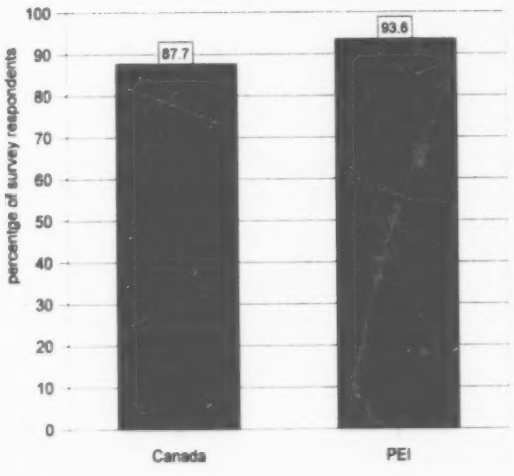
Summary: In 2001 more PEI respondents reported having difficulty obtaining immediate care for a minor health problem than for any of the other two health services reported on for this indicator. Approximately 16% had difficulties during regular daytime hours, 27.9% during evenings and weekends and 18.6% in the middle of the night (see Figure 72). In particular, the PEI weekend and evening rate was high.

11d. Percent of population having a regular family doctor

Definition: Percent of total survey respondents who say "yes" to the question: "Do you have a regular family doctor?"

Rationale: Establishing an on-going relationship with a family doctor is believed to be important in maintaining health and ensuring appropriate access to health services.

Figure 73: Percentage who have a regular family doctor, Canada and PEI, 2001



Source: Health Services Access Survey - Nov -Dec. 2001
Exclusions: same as Figure 70

Summary: In 2001, a very high percentage of PEI respondents (93.6%) reported that they had a family doctor (see Figure 73). This was similar to the national rate of 87.7%.

12. Home and Community Care Services

In recent years, governments have supported programs to deliver some health services to people in their homes, as an alternative to admitting people to acute care or long-term care facilities. This trend has certain benefits, for example: people needing care feel more comfortable; their lifestyles and independence are maintained for as long as possible; facility-based care provided to those with the greatest health care needs; and lower costs are often associated with home care compared to care in institutions.

The following home and community services indicators will be reported: a) admissions to home care services per capita, all ages; b) admissions to home care services per capita, 75+; c) estimated per cent of population receiving homemaking, nursing, physiotherapy or respite services; and d) rates of hospitalization for ambulatory care sensitive conditions.

12a. Admissions to publicly funded home care services per capita

Definition: The number of admissions to publicly funded home care services, including home health and home support services, per capita. This information is based on administrative utilization data collected by the five Regional Health Authorities in the PEI Health and Social Services System.

Rationale: As existing home care services are expanded, it is expected that these services will be provided to increasing numbers of people. Measuring the number of admissions to home care can show how much these services are being used and hence what health needs are being met. Trends in home care volumes can also be compared with trends in utilization of facility-based services to illustrate that increased availability of high quality home care can reduce hospital utilization. High quality home care services would be expected to reduce the need for acute care admissions and to delay or prevent the need for long-term facility care. For example, as home care use among the elderly increases, there should be a corresponding decrease in waiting for long-term care space and an increase in the acuity of long-term care residents.

See results in Table 9.

12b. Admissions to publicly funded home care services per capita 75+

Definition: The number of admissions to publicly funded home care services, including home health and home support services, per capita, for persons 75 years and older. This information is based on administrative utilization data collected by the five Regional Health Authorities in the PEI Health and Social Services System.

Rationale: Same as 12a above.

Home Care and Support Services in PEI: Home Care and Support services are available to medically stable individuals with assessed needs who, without the support of the Program, are at risk of being admitted to an institution in the short term or unable to return to their own home and have adequate family/community support and assistance to sustain the provision of home care services. Services offered include: Home Care Nursing, Community Based Dialysis, Visiting Homemakers, Community Support Services, Occupational Therapy, Physiotherapy, Adult Protection, and Long Term Care Placement.

Table 9: Percentage of population with admissions to publicly funded home care services, including home care and support services, PEI, 1998/99-2000/01
rate (%) = percentage of population

	1998/99 Rate (%)	1999/00 Rate (%)	2000/01 Rate (%)
PEI all ages	1.4	1.3	1.4
PEI age 75+	13.3	12.6	13.0

Source: Ad hoc survey of provincial home care programs, i.e. from all 5 PEI Regional Health Authorities.Two of the regions of the province were unable to provide admissions data for FY 1998/99 and 1999/00. The above figures include an estimated number of admissions for these regions based on the 2000/01 admission data. Also, although some of the data collected has potential for double counting where clients are receiving multiple services from various components of the home care program, the data has been corrected based on estimates.

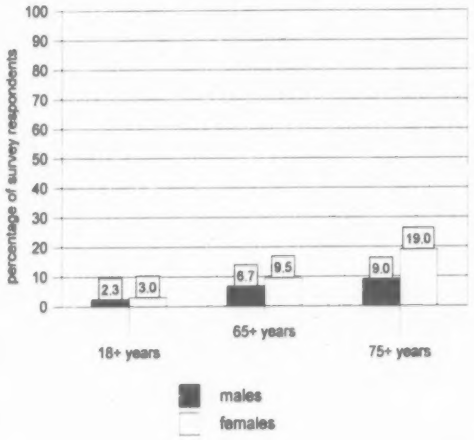
Summary: A relatively small percentage per capita used PEI Home Care and Support services from 1998/99 to 2000/01 at a steady rate of approximately 1.4% (see Table 9). The percentage of persons 75 years and over using those services was considerably higher at a steady average rate of 13.0%.

12c. Estimated percent of population receiving homemaking, nursing or respite services

Definition: The proportion of the population age18 years and over reporting receipt of specified home care services, i.e. homemaking, nursing or respite services. This information is based on self-report by respondents to the Canadian Community Health Survey, 2000/01

Rationale: Estimates of the percent of a population receiving home care services gives a picture of the public perception of home care program use. The public's report of their use of homemaking, nursing or respite services was measured through items on the Canadian Community Health Survey that surveyed a representative sample of 160,000 Canadians in 2000/01. These measures apply to individuals who have received home care services over a 12-month period prior to the survey.

Figure 74: Percentage of population self-reporting use of home care services PEI, 2000/01, by age group



Source: Canadian Community Health Survey - Cycle 1.1 2000/01.
Exclusions: persons less than 18 years of age; persons living on First Nation Reserves and on Crown lands; residents of institutions; full-time members of the Canadian Armed Forces; residents of certain remote regions
Note: Interpret with caution-coefficient of variation between 16.6% and 33.3% : for males - all age groups; for females - 65+
Data was insufficient to report on the 65 to 74 year age group. Therefore, the larger age group of 65+ was reported.

Summary: The self-reported use of home care services in 2000/01 by PEI respondents 18 years of age and older was 2.6% (see Figure 74). This rate was similar to the program admissions of 1.4% for that year reported in Table 9. The self-reported rate for the 65 years and over age group was higher at 8.3%. The rate for the 75 years and over age group has the highest rate at 15.2%, which was similar to the program admissions of 13.0% (see Table 9). The rates across all of these age groups was slightly higher for females than for males.

The age group breakdown typically used in this document has not been reported for this indicator because the data was too unreliable to report (i.e., the coefficient of variation was greater than 33% or the number of observations too small to produce estimates).

12d. Hospitalization rates for ambulatory care sensitive conditions (ACSC)

Definition: In-patient acute care hospitalization rate for conditions where appropriate ambulatory care may prevent or reduce the need for admission to hospital. This rate is age-standardized to reflect the age distribution of the population at large.

Rationale: Hospitalization rates for conditions which can be cared for in the community are one indicator of appropriate access to community-based care. These are long-term health conditions which can often be managed with timely and effective treatment in the community including diabetes, asthma, alcohol and drug dependence and abuse, neuroses, depression and hypertensive disease. Although preventive care, primary care, and community based management of these conditions will not eliminate all hospitalizations, such steps could eliminate many of them. Health care professionals generally believe that managing these conditions before a patient requires hospitalization improves the patient's health, contributes to better overall community health status, and often saves money because community based care usually costs less than hospitalization.

Figure 75: Hospitalization rate (age-standardized) for ambulatory care sensitive conditions, Canada and PEI, 1999/00, by sex

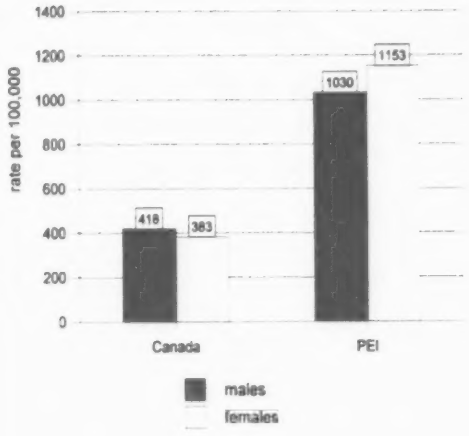
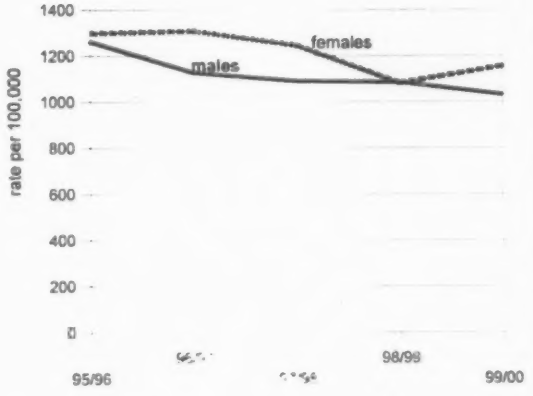


Figure 76: Hospitalization rate (age-standardized) for ambulatory care sensitive conditions PEI, 1995/96 - 1999/00, by sex



Source: Hospital Morbidity Database, CIHI. Census, Statistics Canada. ISQ
Exclusions: patients treated as inpatients in acute care hospitals (e.g. those seen only in an emergency dep[illegible]

Summary: The 1999/00 hospitalization rate for ambulatory care sensitive conditions for PEI at 1,095 per 100,000 population was considerably higher than the national rate of 401. For the same year, there were similar rates for PEI males and females (see Figure 75). Since 1995/96, the overall PEI rate was consistently higher than the Canadian rate but has decreased somewhat from 1,278 per 100,000.

13. Public Health Surveillance and Protection

Communicable / notifiable diseases and their spread are a public health concern. For this reason it is required in legislation to notify health authorities when selected diseases occur in any location. Incidence rates for tuberculosis, HIV, verotoxogenic *E. coli*, and chlamydia are reported for this indicator. These diseases were selected because: they are nationally notifiable; have long-term national trends available; and are of public interest. They also represent the four notifiable disease areas: water borne diseases; food borne diseases; air borne diseases; and diseases that are transmitted sexually or through intravenous drug use. In addition, self-reported exposure to environmental tobacco smoke as a risk factor for various conditions will be reported.

13a. Tuberculosis incidence rate

Definition : Incidence rate of cases of new active and relapsed tuberculosis reported by calendar year.

Rationale: Tuberculosis is an important public health problem that has become more prominent in recent years. The rate of new cases is linked to high-risk groups such as recent immigrants, First Nations communities and people co-infected with HIV. Resistance to multiple drug treatments of the disease is also emerging as a problem. Hence it is important to monitor the occurrence of the disease in the population.

Figure 77: Incidence rate of infectious pulmonary tuberculosis, Canada and PEI, 1999

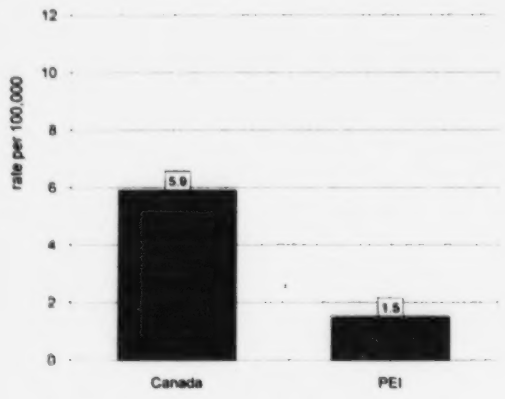
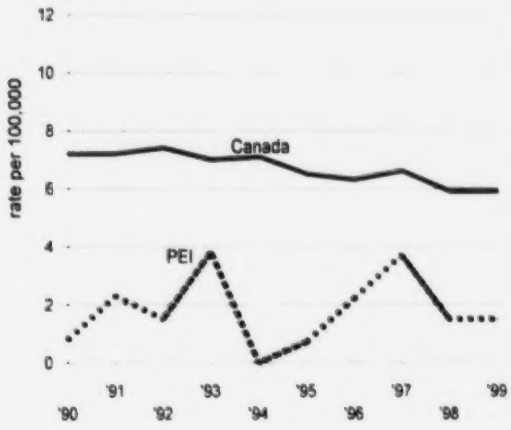


Figure 78: Incidence rate of infectious pulmonary tuberculosis, Canada and PEI, 1990 - 1999



Source: Canadian Tuberculosis Reporting System (CTBRS)

Summary: In 1999, PEI had a very low incidence rate of infectious pulmonary tuberculosis of 1.5 per 100,000 population, lower than the national average of 5.9 (see Figure 77). Over the previous decade, the PEI incidence rate was also consistently lower than the national average (see Figure 78).

13b. Reported HIV diagnoses

Definition: Estimates of new diagnoses of HIV infection, based on new positive HIV test reports per calendar year. This report provides information only on those tested for HIV and does not represent the total number of persons infected with HIV. There are individuals at any given time who do not know that they are infected.

Rationale: In Canada, the rate of decline of new HIV infections has slowed. Since most infections are sexually transmitted this rate can be considered an indicator of high-risk sexual behaviours. The number of new HIV diagnoses is a function of both HIV incidence (i.e., actual number of new cases) and HIV testing patterns. The number of HIV test reports in a given year includes individuals infected in that year as well as individuals infected in previous years. In addition, the number of new diagnoses is also influenced by reporting delays and improved removal of duplicate reports. Therefore changes in the numbers/rates of reported positive tests must be interpreted with caution. Nevertheless, these numbers are useful in tracking HIV.

Figure 79: Rate of new diagnoses of HIV infection, Canada and PEI/Nova Scotia, 2001

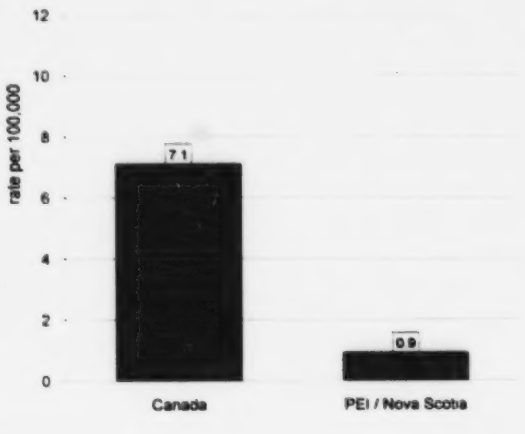
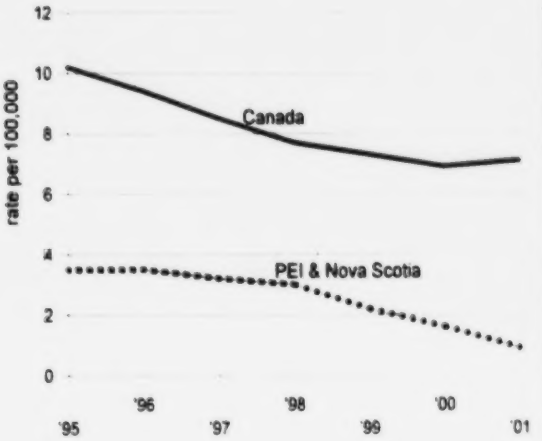


Figure 80: Rate of new diagnoses of HIV infection, Canada and PEI/Nova Scotia, 1995 - 2001*



Source: Health Canada. *HIV and AIDS in Canada. Surveillance report to December 31, 2001.* Division of HIV/AIDS Epidemiology and Surveillance
*1994 data was required for reporting, however 1994 data is not available and therefore has not been reported

Summary: Only data that combines PEI and Nova Scotia is available. In 2001, PEI/Nova Scotia had an HIV diagnosis incidence rate of 0.9 per 100,000 population which was lower than the national rate of 7.1 per 100,000 (see Figure 79). Over the six years prior to 2001, the rate of new diagnoses of HIV declined both in PEI/Nova Scotia and nationally (see Figure 80). Since 1995, the rate in PEI/Nova Scotia has dropped from 3.5 to less than 1 per 100,000.

13c. Verotoxogenic *E. coli* incidence rate

Definition: The rate of new cases of verotoxogenic *E. coli* reported by calendar year.

Rationale: The incidence of verotoxogenic *E. coli* may be considered an approximate indicator of food-borne illness in general and is therefore important to monitor in terms of public health. It also has implications for water-borne disease issues. *E coli* 0157 is included in the category of verotoxogenic *E. coli* (VTEC), accounting for more than 90% of cases. All provinces and territories may be required to report on VTEC in the future. PEI currently reports on VTEC.

Figure 81: Incidence rate of verotoxogenic *E. coli*, Canada and PEI, 2001*

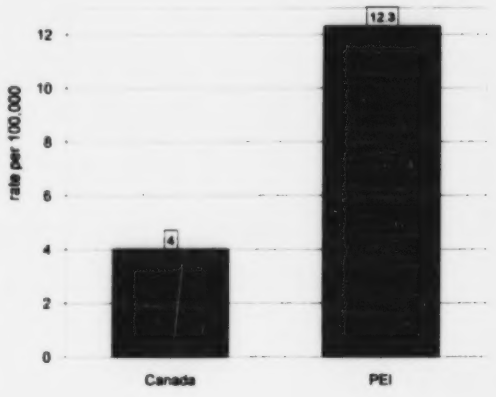
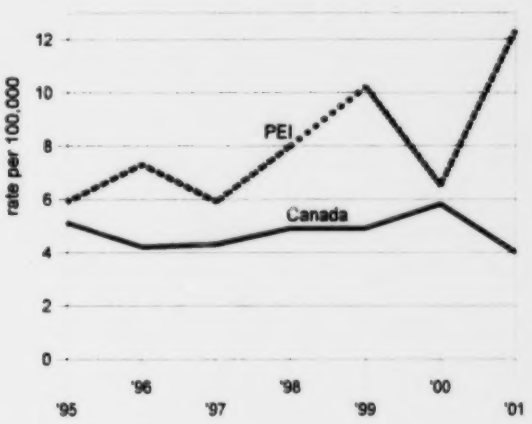


Figure 82: Incidence rate of verotoxigenic *E. coli*, Canada and PEI, 1995-2001*



Source: Notifiable Disease Records
* The data currently available for 2000 and 2001 are still preliminary and are subject to change.

Summary: In 2001, PEI had a considerably higher verotoxigenic *E. coli* incidence rate of 12.3 per 100,000 population than the national average of 4.0 (see Figure 81). Over the six years prior to that, PEI's rate was also consistently higher than the national rate (see Figure 82). Because verotoxigenic *E. coli* is a reportable disease in PEI, all cases get reported. It is not a reportable disease in all provinces and territories across Canada, so the national rate may have inconsistencies and reflect a lower rate than is actually present in Canada.

13d. Chlamydia incidence rate

Definition: Incidence rate of reported genital infections (chlamydia) by calendar year.

Rationale: Chlamydia is a genital infection and a common sexually transmitted disease which may result in female infertility and ectopic pregnancy. The incidence of chlamydia and other sexually transmitted diseases continues to increase. The higher incidence rates of chlamydia relative to other sexually transmitted diseases means this measure is a more sensitive indicator of change in risk behaviours and reflects the effectiveness of primary and secondary prevention.

Figure 83: Incidence rate of chlamydia, Canada and PEI, 2000*

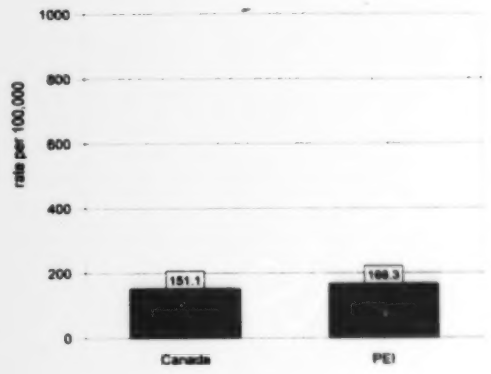
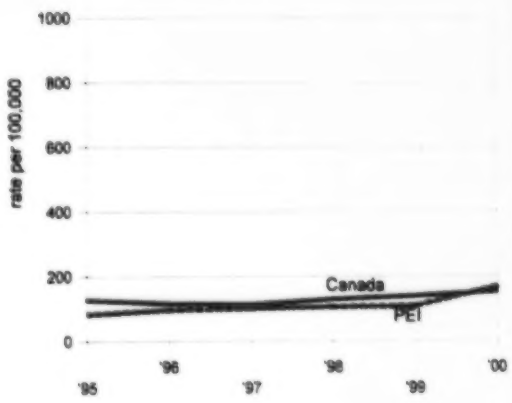
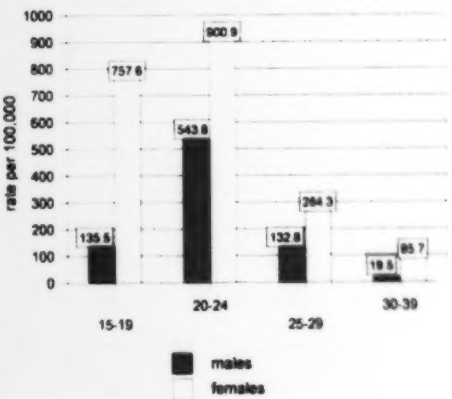


Figure 84: Incidence rate of chlamydia, Canada and PEI, 1995 - 2000*



Source: Notifiable Disease Records Division of Sexual Health Promotion and STD Prevention & Control, Bureau of HIV/AIDS, STD & TB, Health Canada, 2001
* The data currently available for 2000 are still preliminary and are subject to change

Figure 85: Incidence rate of chlamydia, PEI, 1999, by sex and age group



Source: Notifiable Disease Records Division of Sexual Health Promotion and STD Prevention & Control, Bureau of HIV/AIDS, STD & TB, Health Canada, 2001

Summary: For 2000, the PEI incidence rate of chlamydia for all ages at 166.3 per 100,000 population was just above the national average of 151.1 (see Figure 83). Over the five years prior to 2000, the PEI incidence rate has been just under the national average (see Figure 84). In the younger age groups (i.e. 15 to 24 years), the incidence rate was much higher for females than for males. For example, PEI females age 15-19 years had a rate of 757.6 per 100,000 and those 20-24 years had a rate of 900.9.

When looking at this data, it should be noted that the numbers reflect only the reported cases. In Canada, it is estimated that three quarters of female infections and half of male infections are asymptomatic and many remain undiagnosed.

13e. Exposure to environmental tobacco smoke

Definition: Proportion of the non-smoking population who reported being regularly exposed to environmental tobacco smoke on the Canadian Community Health Survey 2000/01. Regular exposure is defined as being exposed to second hand smoke on most days within a month.

Rationale: This indicator reflects the effectiveness of the public health system in protecting non-smokers against exposure to environmental tobacco smoke. The relationship between environmental tobacco smoke and adverse health effects is well documented. Besides being a known mucous membrane irritant, second-hand smoke exposure is linked to respiratory illness and increases in mortality from lung cancer and cardiovascular disease. Second-hand smoke has serious consequences for children: smoking mothers bear children with lower birth weights, and children living in homes where they are exposed to tobacco smoke have higher rates of asthma and respiratory tract problems.

Figure 86: Percentage of the non-smoking population, age 12 to 19 years, self-reporting regular exposure to environmental tobacco smoke Canada and PEI, 2000/01, by sex

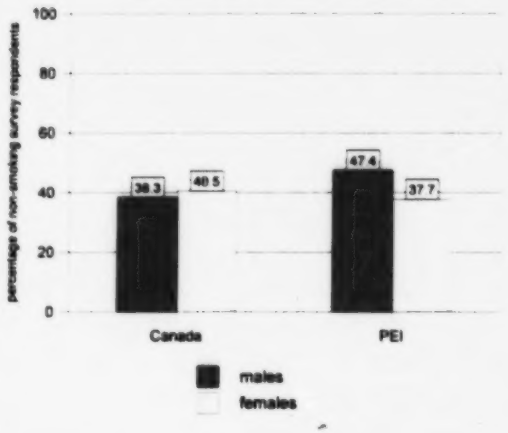
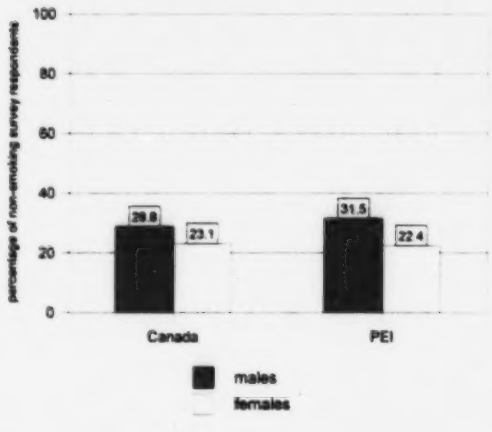


Figure 87: Percentage of the non-smoking population, age 20+, self-reporting regular exposure to environmental tobacco smoke, Canada and PEI, 2000/01, by sex



Source: Canadian Community Health Survey - Cycle 1.1 2000/01
Exclusions: persons less than 12 years of age; persons living on First Nation Reserves and on Crown lands; residents of institutions; full-time members of the Canadian Armed Forces; residents of certain remote regions

Summary: In 2000/01, the percentage of 12 to19 year olds self-reporting regular exposure to environmental tobacco smoke in PEI was 42.6% which was similar to the national average 39.3% (see Figure 86). The PEI rate for males was somewhat higher than that of females. The rates for the 20+ age group for PEI and Canada were considerably lower than those of the 12 to 19 year olds. The rates for males and females in the 20+ age group were similar for PEI and Canada (see Figure 87).

14. Health Promotion and Disease Prevention

The following indicators provide a picture of some key personal health behaviours with respect to smoking, physical activity, obesity and flu immunization and of the success of health promotion and disease prevention in these areas. These indicators were measured through items on the Canadian Community Health Survey that surveyed a representative sample of 160,000 Canadians in 2000/01 and historically from the National Population Health Survey 1994, 1996 and 1998.

14a. Percent teenaged smokers

Definition: Percentage of the population aged 12 to 19 reporting they were a) current smokers and b) daily smokers, on the Canadian Community Health Survey, 2000/01.

Rationale: Tobacco use is the leading cause of preventable illness and death in Canada. Health Canada estimates that smoking is responsible for more than 45,000 deaths per year. The indicator is the proportion of those aged 12-19 who report current smoking was selected because the addictive nature of nicotine means that youth smoking is of particular concern. It is estimated that approximately 8 out of every 10 people who try smoking become habitual smokers.

Figure 88: Percentage of self-reported current smokers, age 12-19, who smoke daily Canada and PEI, 2000/01

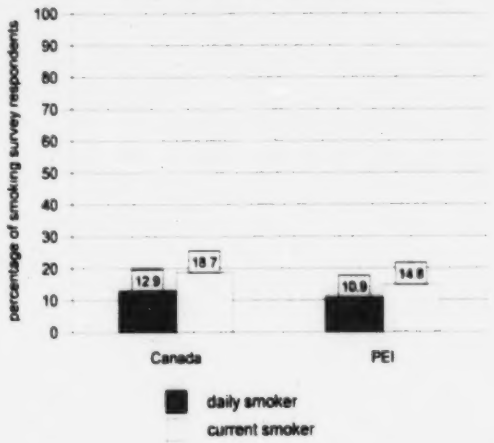
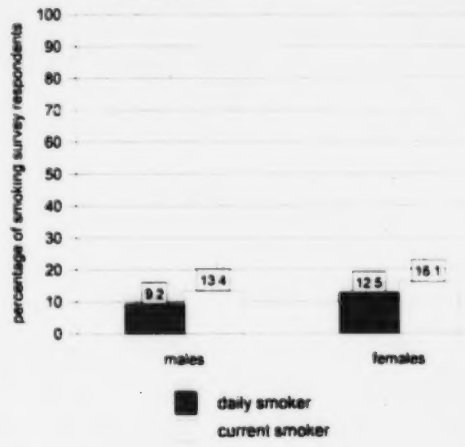
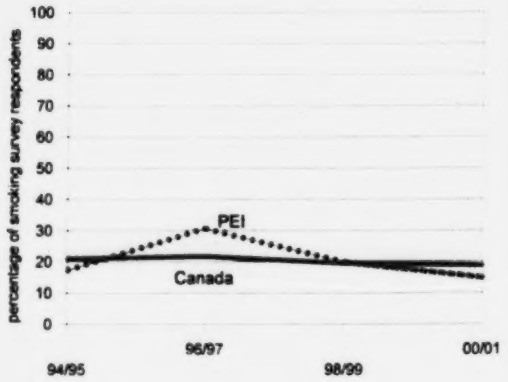


Figure 89: Percentage of self-reported current smokers, age 12-19, who smoke daily PEI, 2000/01, by sex



Source: Canadian Community Health Survey - Cycle 1.1 2000/01
Exclusions: persons less than 12 years of age; persons living on First Nation Reserves and on Crown lands, residents of institutions, full-time members of the Canadian Armed Forces, residents of certain remote regions
Note: Interpret with caution-coefficient of variation between 16.6% and 33.3% - all PEI data

Figure 90: Percentage of age 12-19 who reported being current smoker, Canada and PEI, 1994/95-2000/01



Source: Canadian Community Health Survey - Cycle 1.1 2000, National Population Health Survey, 1994, 1996, 1998
Exclusions: same as for Figure 88
Note: Interpret with caution-coefficient of variation between 16.6% and 33.3% for males, all PEI data except for 2000/01

Summary: For 2000/01, the rate of self-reported current smokers and daily smokers, age 12 to 19, in PEI was similar to the national average (see Figure 88). For both Canada and PEI, approximately three quarters of the current smokers report that they smoke on a daily basis. In PEI 16.1% of females, age 12-19 years, reported being current smokers, and approximately three quarters of them reported smoking daily (see Figure 89). The rates for females were somewhat higher than the rates for males. Over the six years from 1994/95, the self-reported rates of smoking varied somewhat on PEI and nationally (see Figure 90).

14b. Physical activity

Definition: Percentage of the population aged 12 and over who reported a physical activity index of "active"and "inactive", on the Canadian Community Health Survey, 2000/01.

Rationale: Maintaining physical activity is associated with a range of health benefits. For example, many studies have shown that regular physical activity has major heart health benefits, that inactivity is a major risk factor for heart disease and that physically active individuals are less likely to become depressed.

14b(i). Physically active

Figure 91: Percentage self-reporting as physically "active", Canada and PEI, 2000/01

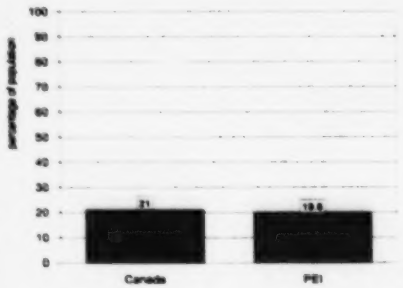
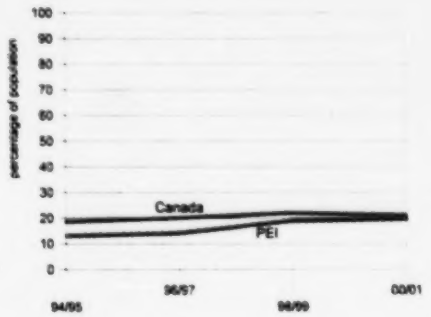
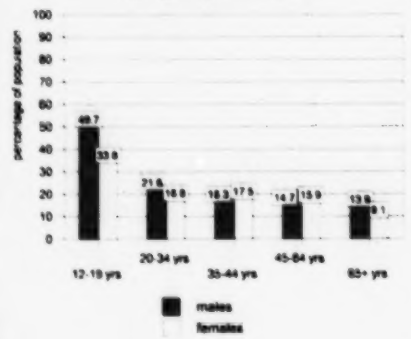


Figure 92: Percentage self-reporting as physically "active", Canada and PEI, 1994/95-2000/01



Source: Canadian Community Health survey - Cycle 1.1, 2000/01, National Population Health Survey, 1994, 1996, 1998
Exclusions: same as for Figure 88

Figure 93:Percentage of population self-reporting as physically "active", PEI, 2000/01, by age group and sex



Source: Canadian Community Health survey - Cycle 1.1, 2000/01
Exclusions: same as for Figure 88
Note: Interpret with caution-coefficient of variation between 16.6% and 33.3% : males 65+

Summary: In 2000/01, PEI and Canada had similar low self-reported percentages of respondents who reported a physical activity index of "active" (see Figure 91). Over the five years prior to that, PEI rates had been similar to the national average rates and had changed somewhat (see Figure 92). In terms of sex differences, males appeared to be more active overall (see Figure 93). This was particularly noticeable in the 12 to19 age group. As well, being physically active appeared to decline with age, with a large decrease from the12-19 age group to the 20-34 age group (see figure 93).

14b(ii) Physically inactive

Figure 94: Percentage self-reporting as physically "inactive",Canada and PEI, 2000/01

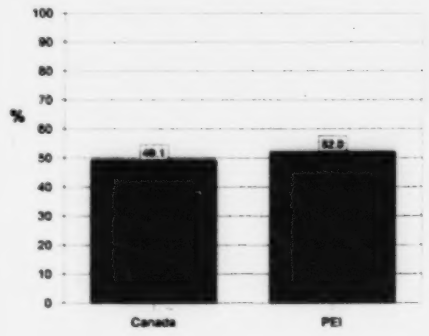
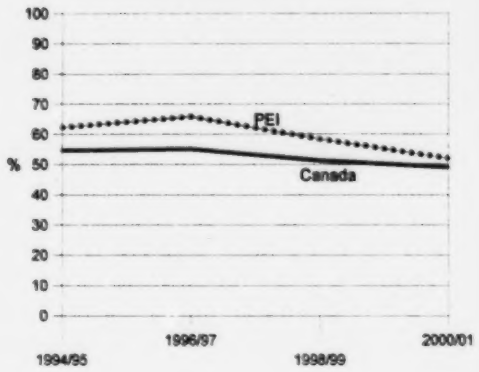
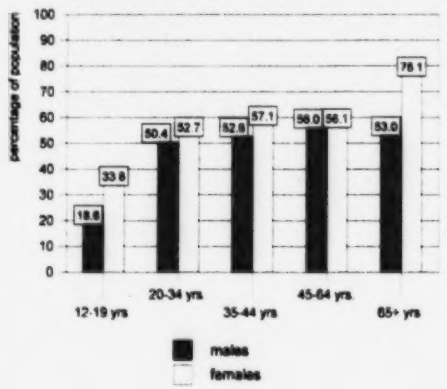


Figure 95: Percentage self-reporting as physically "inactive", Canada and PEI, 1994/95- 2000/01



Source: Canadian Community Health survey – Cycle 1.1, 2000/01; National Population Health Survey, 1994, 1996, 1998
Exclusions: same as for Figure 88

Figure 96: Percentage self-reporting as physically "inactive", PEI, 2000/01, by age group and sex



Source: Canadian Community Health survey – Cycle 1.1, 2000/01
Exclusions: same as for Figure 88
Note: Interpret with caution-coefficient of variation between 16.6% and 33.3% : males 12-19

Summary: In 2000/01, just over half of the PEI respondents reported a physical activity index of "inactive", similar to the Canadian rate (see Figure 94). This was more than twice as many as those who reported being active on the physical activity index. Over the previous five years, PEI inactivity rates were similar to the national average rates and have decreased slightly (see Figure 95). Inactivity appeared to increase with age especially for females (see Figure 96).

14c. Body mass index (BMI)

Definition: Percent of adults who report a computed body mass index (BMI) in specified categories ranging from underweight to obese. Body mass index is based on self-reported height and weight from the Canadian Community Health Survey, 2000/01. The BMI categories are: <18.5 is underweight; 18.5-24.9 is an acceptable weight; 25-29.9 is overweight; and 30 or higher is obese.

Rationale: Obesity has been identified as a major risk factor contributing to a number of chronic illnesses such as diabetes and heart disease. The effect of excess weight as a risk factor increases with a BMI above the threshold of 25. BMI is the most common method of determining if an individual's weight is in a healthy range and is calculated as weight (in kilograms) divided by height (in meters) squared. However, data on height and weight is based on self-report survey responses and individuals may not always report reliably.

Figure 97: Percentage age 20-64 by BMI category, PEI and Canada, 2000/01

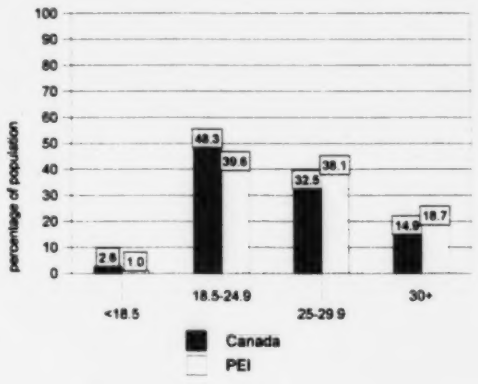
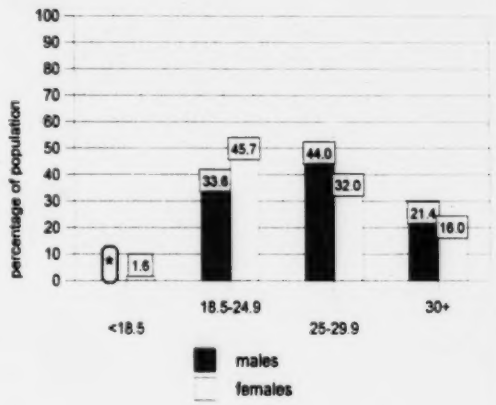


Figure 98: Percentage age 20-64 by BMI category, PEI, 2000/01, by sex



Source: Canadian Community Health survey – Cycle 1.1, 2000/01; National Population Health Survey, 1994, 1996, 1998
Exclusions: same as for Figure 88, except with persons less than 20; as well, pregnant women, and persons less than 3 feet or greater than 6 feet in height
Note: Interpret with caution-coefficient of variation between 16.6% and 33.3%: PEI BMI <18
* Data not reported because coefficient of variation greater than 33% or number of observations too small to produce estimate

Summary: For the population age 20 to 64 years, close to 50% of Canadian respondents and 40% of PEI respondents reported a body mass index that was of acceptable weight (BMI=18.5-24.9) (see Figure 97). A very small percentage of individuals reported being underweight (BMI under 18.5). However, a large percentage of the 20 to 64 year old age group are either overweight or obese (BMI over 25), i.e. 56.8% for PEI and 47.4% for the national average. These are interesting figures given that 52.0% of Island respondents and 49.1% of Canadian respondents also reported being physically inactive (see indicator 14b). In PEI, over 10% more females than males reported being an acceptable weight and 17.4% more males than females reported being either overweight or obese (see Figure 98).

14d. Immunization for influenza

Definition: Percent of the population 65 and over and over who reported having had a flu shot in the year prior to the Canadian Community Health Survey, 2000/01.

Rationale: Immunization for influenza has been shown to be effective for adults over 65. This indicator reports the time of last immunization.

Figure 99: Percentage of population age 65-74 self-reporting flu shot, by time period Canada and PEI, 2000/01

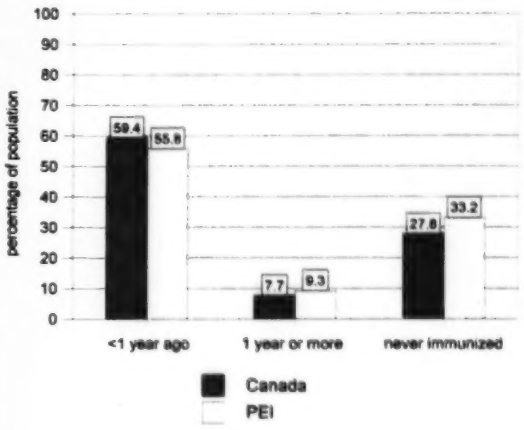
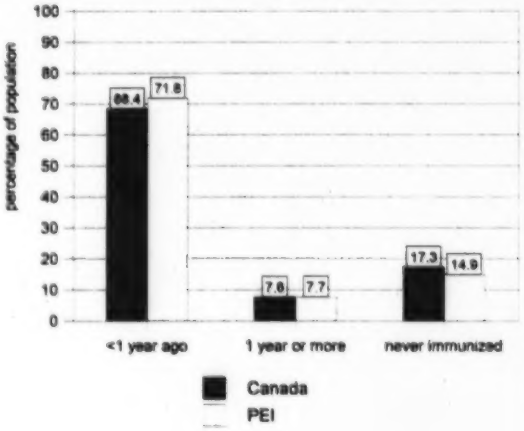
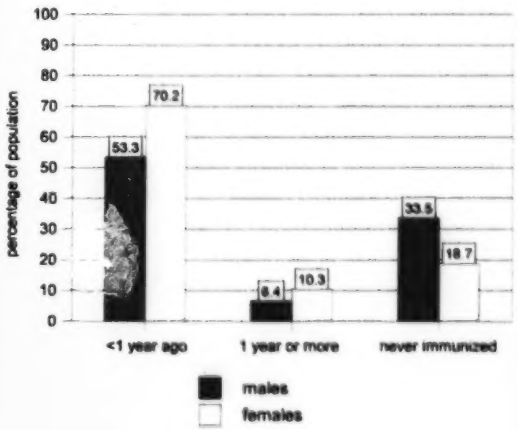


Figure 100: Percentage of population age 75+ self-reporting flu shot, by time period Canada and PEI, 2000/01



Source: Canadian Community Health survey – Cycle 1.1, 2000/01; National Population Health Survey, 1994, 1996, 1998
Exclusions: same as for Figure 88
Note: Interpret with caution-coefficient of variation between 16.6% and 33.3%: PEI rates for >1yr and 75+ never immunized

Figure 101: Percentage of population age 65+ self-reporting flu shot, by time period, by sex, PEI, 2000/01



Source: Canadian Community Health survey – Cycle 1.1, 2000/01; National Population Health Survey, 1994, 1996, 1998
Exclusions: same as for Figure 88

Summary: In 2000/01, just over half of PEI and Canadian respondents age 65 to 74 reported having been immunized for the flu within the last year (see Figure 99). Approximately 33% of Islanders in this age group reported never having had a flu shot. For those that are 75 years or older, the self-reported rate for flu shot during 2000/01 was even higher. The PEI rate was 71.8% and the Canadian average was slightly less at 68.4% (see Figure 100). For PEI, more women than men 65 years and over reported having been immunized within the last year.

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